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A Feasibility Study of IPV among Gay Men in Metro Atlanta Using Social Media

By

Ken Chen

B.S., Communications
KENNESAW STATE UNIVERSITY

B.S., Biochemistry and Molecular Biology
UNIVERSITY OF GEORGIA

M.S., Conflict Management
KENNESAW STATE UNIVERSITY

M.B.A.
SOUTHERN POLY STATE UNIVERSITY

A Thesis Submitted to the Graduate Faculty
of Georgia State University in Partial Fulfillment
of the
Requirements for the Degree

MASTER OF PUBLIC HEALTH

ATLANTA, GEORGIA
30045

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Acknowledgements

I would like to thank Dr. Sheryl Strasser for her ongoing guidance and support as my thesis chair. Dr. Strasser's expertise, understanding, and support of this thesis process were invaluable. She continually engaged my interest in the field of violence prevention and was instrumental in keeping the momentum of the project moving. Additionally, I would like to thank Dr. Frances McCarty for serving on my committee. Her knowledge in statistics allowed me to critically analyze my research results. I am very grateful for the Institute of Public Health for providing me with the opportunity to pursue my educational goals to obtain a Masters degree.

Furthermore, I would like to acknowledge my team lead (Karen Eilola-Miller) and branch chief (Kathleen Dunlap) at the Centers for Disease Control and Prevention for allowing me to complete this degree. Your continual support and accommodation made it possible for me to complete this wonderful experience.

Lastly, I would like to thank my partner, Neil Hall, for his support and patience throughout the coursework and thesis process. Your encouragements and dedication to our community inspired me to speak for those without a voice.

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APPROVAL PAGE

A Feasibility Study of IPV among Gay Men in Metro Atlanta Using Social Media

by

KEN CHEN

Approved:

_____

Committee Chair

_____

Committee Member

_____

Committee Member

_____

Date

ABSTRACT

KEN CHEN
A Feasibility Study of IPV among Gay Men in Metro Atlanta Using Social Media

Intimate Partner Violence (IPV) is a major public health issue occurring in the United States and globally. While little is known in general about IPV, understanding about the prevalence of physical IPV among gay men is even more obscure. Scientific literature indicates that harmful lifestyle health behaviors (alcohol and drug abuse, smoking, and risky sexual behaviors) are associated with the increased occurrence of IPV. Intimate Partner Violence in same-sex relationships is often unreported due to society's emphasis on "moral closets" or the fear of potential repercussions. As a result, very few empirical researches have been conducted on the phenomenon of same-sex partner abuse. This study was conducted to examine the feasibility of enrolling 100 gay men from Atlanta into an IPV survey study. The survey was administered via Facebook. Ninety-nine usable surveys were collected. Chi-square tests reveal that being Non-White, using substances (alcohol, tobacco, and elicit drugs) and non-disclosed orientation status were all significantly associated with positive IPV reports. Overall, the study sample believes IPV is a health problem in the Atlanta gay community. These findings bear great importance for the Atlanta gay community and public health professionals who must address this nearly invisible yet increasing public health issue.

INDEX WORDS: Intimate Partner Violence (IPV), gay male, same-sex, physical violence, victims, perpetration, and substance risk behaviors.

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Student's Name: Ken Chen

Street Address: 950 West Peachtree Street, Unit 605

City, State, and Zip Code: Atlanta, GA 30309

The Chair of the committee for this thesis is:

Professor's Name: Dr. Sheryl Strasser

Department: Institute of Public Health

College: Health and Human Sciences

Georgia State University
P.O. Box 3995
Atlanta, Georgia 30302-3995

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Chapter I

INTRODUCTION

1.1 Background

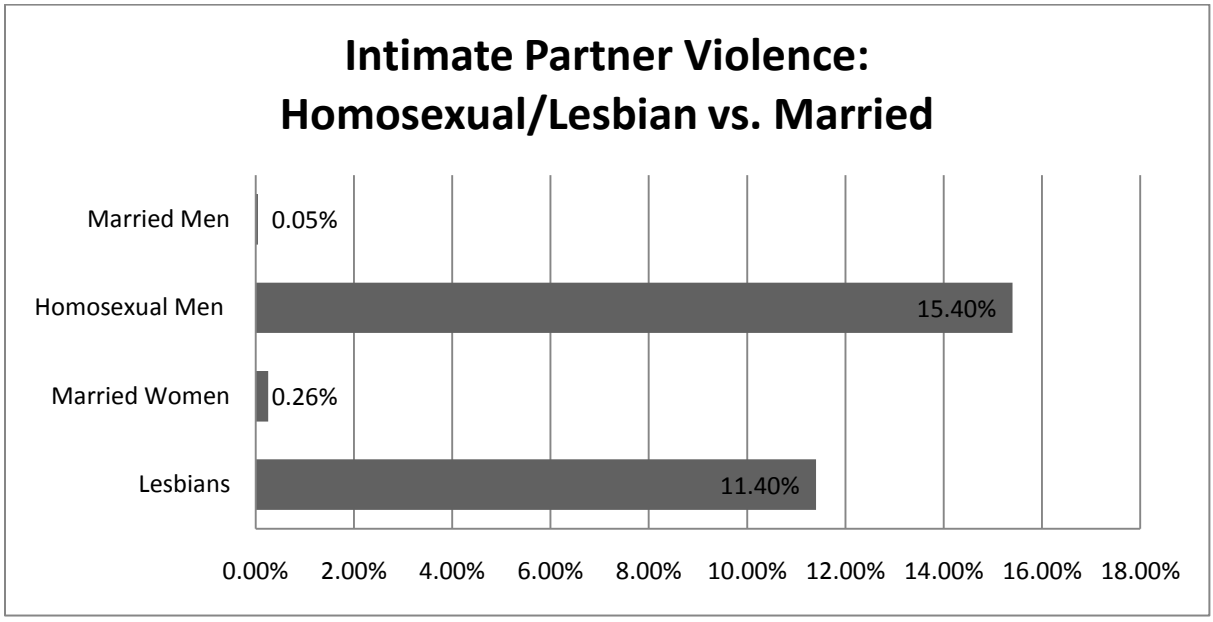
In general, domestic violence laws fail to protect individuals of same-sex relationships. Historically there have been egregious cases, such as the example of serial killer Jeffery Dahmer, that likely would not have involved so many victims had there been law enforcement intervention. However, despite the high profile incidents, several states such as Delaware, Indiana, Michigan, and Washington, specifically exclude same-sex partner violence protection in the domestic violence legislature (Jablow, 2000). While today many states still do not have same-sex IPV protection laws; among those states having gender-neutral statutes—it has been found that these only provide minimal protection. Individuals facing IPV may find state laws ambiguous and/or unhelpful. Gay, lesbian, bisexual, and transgender (GLBT) communities face a unique challenge in obtaining legal protection and the disparity continues to exist today. Violent episodes are often unreported and the cycle of violence continually perpetuates preventable suffering.

Gay Male IPV is a Public Health Issue

According to the Centers for Disease Control and Prevention (CDC), IPV is a major public health issue (2009). It accounts for 7.7 million physical assaults each year: women (62%) and men (38%), but many more incidents are unreported (Tjaden, 2000). It is likely that same-sex IPV events are among the many unreported cases. Various explanations have attempted to explain the reporting discrepancy and one repeating theme is evident. The theme is that the scope and nature of IPV in same-sex relationships is grossly unknown. It has been estimated that the prevalence of violence in same-sex couples is 25-33%, which is comparable to heterosexual relationships (Barnes, 1998). A recent Department of Justice Report (DOJ) revealed that IPV incidence rates were higher in same-sex relationships, especially among women (DOJ, 2000). This finding is further supported by research led by Greenwood and colleagues (2002) and Tjaden and Thoennes (2000).

Research on same-sex partners was virtually nonexistent until the 1990's (Renzetti, 1992). While most research studies attempted to elucidate the intricacies of same-sex IPV via empirical analysis, the findings are inconclusive because contextual factors such as settings and stressors were not considered (Cascardi & Vivian 1995). Studies of same-sex IPV agree that the subject matter is a poorly understood phenomenon (Stanley et al., 2006; Brown, 2008). One justification behind the delay of same-sex IPV studies is the concept of "a moral closet": an implication that same-sex relationships should remain hidden (Brown, 2008). Intimate Partner Violence is now the third largest public health issue facing gay men, following HIV/AIDS and substance abuse (Peterman & Dixon, 2003). In a comparative study conducted by the U.S. DOJ, findings indicate that IPV was more prevalent among same-sex relationships (Figure 1), yet very little was known about same-sex IPV.

Figure 1. Comparison of IPV between Same-Sex and Married Relationships-2000



Adapted from: "Extent, Nature, and Consequences of Intimate Partner Violence," U.S. Department of Justice: Office of Justice Programs: 30; "Intimate Partner Violence," Bureau of Justice Statistics Special Report:11.

Definition of Terminology

Domestic violence (DV) is defined as, "a pattern of behavior where one intimate partner coerces, dominates, and isolates the other intimate partner in order to maintain power and control over the partner and over the relationship…can also be inclusive of any violence which happens in the home (between parent and children, roommates, etc.)" (National Coalition of Anti-Violence Programs [NCAVP], 2008 p.6). Intimate Partner Violence is defined as "violence between two people in close relationship which includes current and former spouses and dating partners" (CDC, 2009). The precise terminology of IPV is used to describe specific patters within intimate relationships and it falls under the overarching umbrella of DV. The World Health Organization (WHO) further elaborated IPV to include "acts of physical aggression, psychological abuse, forced intercourse and other forms of sexual coercion, and various controlling behaviors such as isolating a person from family and friends or restricting access to

information and assistance" (2002). Some of the immediate and long-term negative physical and psychological manifestations of IPV victimization include physical injury, chronic pain syndromes, gastrointestinal disorders, and depression or suicidal behaviors (WHO, 2002).

Same-sex IPV in Atlanta

The US Bureau of the Census' Population Estimates Program (PEP) estimated (from the 2000 Census of Population Survey) in 2000 that there were about 416,474 people living in Atlanta, Georgia (2010). The number of unmarried same-sex partner in the households, are 11,402 out of the 416,474 people or 2.7 %. This number is used in an index to indicate the number of same-sex partners living together in Atlanta. The gay index comparative score found, according to 2000 US Census data, Atlanta has an overall average index score of 299. For gay males specifically, the index score is 419 and for lesbians an index score of 175 (Gates, 2007). The national norm for this index is 100, which means Atlanta has almost 200% more same-sex partners living together than the national average. The Center for Positive Aging has identified 13% of Atlanta's population as Lesbian Gay Bisexual Transgender [LGBT] (2010). Moreover, the Williams Institute ranked Atlanta as the 3rd city with the highest percentage of gays, lesbians, and bisexuals (Romero et al., 2008).

1.2 Purpose of Study

According to Greenwood and colleague's study in the *American Journal of Public Health*, the rate of IPV between urban gay men is a "very serious public health problem" (2002, p.1969). The study reported a 22% prevalence rate of various forms of physical abuse among the study population. The purpose of this study is to determine if age, ethnicity, alcohol/drug use,

and risky sexual behavior are associated with reports of IPV among a sample of gay males in Atlanta, Georgia. An electronic survey was used to collect data on IPV victimization and perpetration among gay (disclosed and non-disclosed) men. For clarification purposes, "same-sex" and "men" refers to only gay males in this study.

1.3 Research Questions

1. How does education level correlate with reported physical IPV among the study sample?
2. Does disclosure status of participants significantly relate with positive reports of IPV?
3. How does age associate with reported physical IPV among the study sample?
4. How does alcohol or other substance use associate with reported physical IPV among the study sample?
5. How does ethnicity associate with reported physical IPV among the study sample?

The sections that follow in this document will present the published support, methodology, results and interpretation of answer to these study questions.

Chapter II

REVIEW OF THE LITERATURE

In this chapter, support for this study's research questions is synthesized from the scientific literature. Much of what is presented in terms of risk factors and negative health outcomes tied to IPV stem from research that focuses primarily on heterosexual relationships.

2.1 Problem of IPV

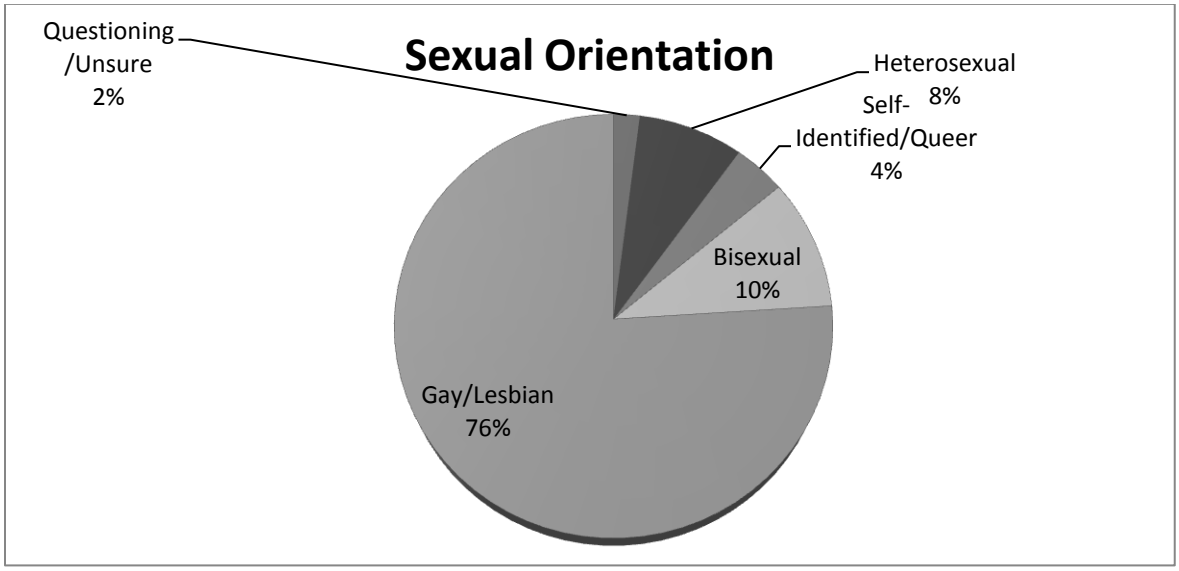
A significant body of evidence cites positive correlation between health problems and increase exposures of IPV (Acierno, Resnic, & Kilpatrick, 1997; Coker, Davis, Arias, et al. 2002; Heise & Garcia-Moreno, 2002). The range of IPV behaviors among same-sex partners does not differ from heterosexual relationships and they include physical, psychological, sexual, emotional, and verbal acts, and often involve substance abuse. Health-related consequences of IPV include increased rates of hypertension, obesity, and sexually transmitted infections; and gay men in abusive relationships are more likely to engage in unprotected sex and substance abuse (Houston & McKirnan, 2007). Emotional stress, especially for depression, appeared to be most prevalent in same-sex relationships. Houston & McKirnan (2007) tested for five psychosocial variables: depression, social support/isolation, sexual safety, self-esteem, and outness (2006).

Their study found depression is the only variable that is significantly higher for men exposed in IPV (2007).

Disclosure vs. Non-Disclosure

A unique factor found in same-sex IPV is the power of "outing". Victims of IPV may not verbally acknowledge their sexuality status (or be "out") to family, friends, or co-workers. As a result, the feeling of shame or disgrace helps to perpetuate victims' tendency to remain in abusive relationships. Same-sex victims often forgo filing report of violence due to societal homophobia and the pressure to live within the confinement of the "moral closet" (McClennen et al, 2002). Positive scores of increased isolation and thoughts of suicide have been found with gay men whose families and friends are unsupportive of their lifestyle choices. Victims who are not "out" publically may be reluctant or unwilling to seek help from authorities or other services because it would require them to disclose their sexuality and possibly face embarrassment or harassment (Merrill, 2000). The NCAVP has found that in 2008, 76% of all IPV in the US occurs within gay/lesbian relationships (Figure 2).

Figure 2. Sexual Orientation of Victims & Survivors-2008

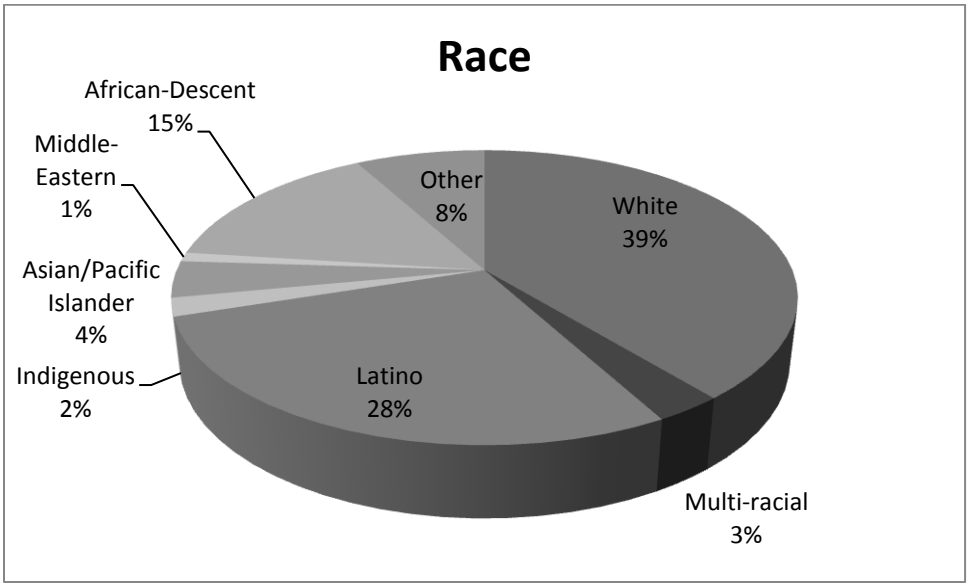


Adapted from: NCAVP, LGBTQ Domestic Violence in 2008:24.

Race/Ethnicity

The current body of knowledge contains discrepant information on same-sex IPV. The Bureau of Justice Statistics (2000) found that blacks have a significantly higher rate of victimization than any other race; however, Greenwood et al (2002) found that IPV involving men in same-sex relationship does not appear to be associated with racial or ethnic identity. The NCAVP (2010) found in 2008 that the 39 % of same-sex IPV occurs among whites and 28% Latinos (Figure 3). The variation may be due to bias in the random sampling.

Figure 3. Race/Ethnicity of Victims & Survivors in LGBTQ Domestic Violence-2008



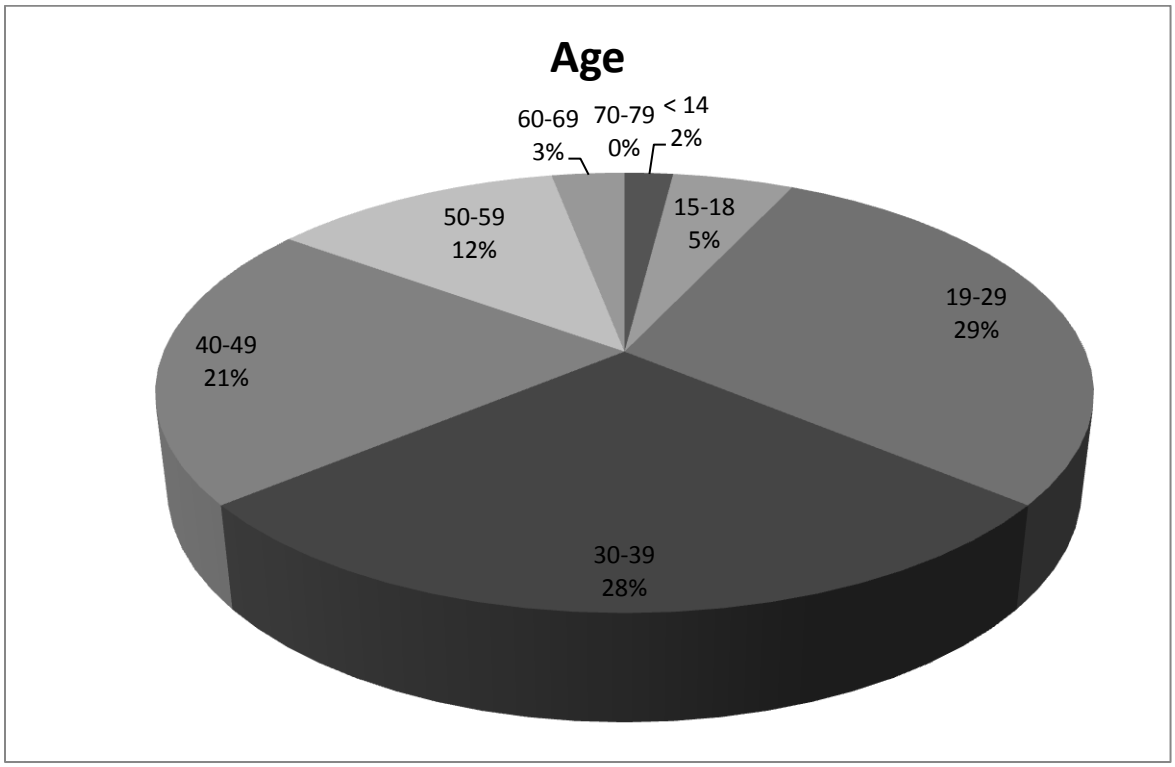
Adapted from: NCAVP, LGBTQ Domestic Violence in 2008:24.

Age

Young age has been linked to men's likelihood of physically assaulting an intimate partner (Moffitt & Caspi, 1999). The Bureau of Justice (2006) found that older individuals (regardless of sexual orientation) are more likely to be IPV victims than are younger individuals. What is interesting about these two studies is that victims are often older in age while

perpetrators are younger in age. In 2008, 29% of male same-sex IPV occurred between the age of 19 to 29 and 28% between the age of 30 to 39 (NCAVP, 2008. Figure 4).

Figure 4. Age of Victims & Survivors in LGBTQ Domestic Violence-2008



Adapted from: NCAVP, LGBTQ Domestic Violence in 2008:24.

Alcohol & Other Drug Usage

Alcohol abuse is another salient factor in same-sex IPV and has been found to have higher incidences than heterosexuals (Bradford, Ryan, & Rothblum, 1994). One explanation of this variation is that alcohol is a common way of dealing with stress exacerbated by homophobia (Schilit & Montagne, 1990). Internalized homophobia has been linked to self-destructive behaviors such as substance abuse (Coleman, 1994). In America's homophobic society, same-sex IPV perpetrators and victims are being silenced in the "double-closet"- entombment of same-gender identity and personal pain of abuse (McClennen, 2005). Same-sex victims and abusers

may not seek intervention, such as substance abuse programs or medical guidance, because of shame and/or fear. As a result, rates of drug (prescription and illicit) and alcohol abuse have been found to be are higher among couples involved in same-sex IPV (Schilit & Montagne, 1990).

Risky Sexual Behaviors

Risks of HIV sexually-transmitted disease (STD) among victims of same-sex IPV has been examined in the research (McLaughlin & Rozee, 2001). Studies have demonstrated that men who experienced IPV within a same-sex relationship are between 50% to 60% more likely to be HIV positive than those who had not experienced in any types of abuse (Greenwood et al., 2002; Stall et al., 2003). Sexual behavior is an important consideration for IPV study since HIV/STD can occur directly through forced unprotected sex. Heintz and Melendez (2006) cite the rates of STD in their sample were high in LGBT people who experienced IPV.

Although the causation of IPV and HIV has not been established, the inability to negotiate safe sex practice may contribute to power imbalance in the relationship. The health outcomes of these decisions can lead to higher incidences of HIV/STD. Victims of IPV often do not practice safe sex because they fear their partner's response may result in more sexual, physical, and/or verbal abuse (Heintz & Melendez, 2006). Examining same-sex IPV and HIV/STD risk including safer sex negotiation is important in increasing violence awareness in the LGBT communities (McGaughlin & Rozee, 2001).

2.2 Other Characteristics

High level of masculinity has been found to be a prominent indicator of IPV. Gay men and lesbians who identified with more masculine personalities are likely to become abusive (McConaghy & Zamir, 1995). Burke and Flingstad (1999) found that regardless of sexual orientation, masculine gender role orientation has a positive association with violence. Other individual characteristics that may contribute to same-sex IPV are the level of education, socioeconomic status (SES), race, and relative power (McLaughlin & Rozee, 2001). Houston and McKirnan (2007) reported significant differences of IPV occurrences between high SES and middle to lower SES. Higher SES provided some degree of immunity to same-sex IPV. Problem solving skills such as negotiating or compromising obtained through education or personal experience may have provided some buffer (Kurdek, 2005; Peplau & Fingerhut, 2007).

Individual propensity of attachment, especially insecure attachments, is another variable in predicting IPV (Rensetti, 1992). Following power imbalance, dependency and jealousy are the two major factors contributing to same-sex IPV. Due to socialization of expected gender roles, failed intervention of IPV among gay males may be due to popular myths. Myths such as “boys will be boys” minimizes the severity of IPV. For this reason, men rarely talk about abuse for the fear that they will be feminized (Island and Letellier, 1991).

2.3 Theoretical Perspectives of Same-Sex IPV

According to the Disempowerment Theory, individuals who feel lacking of self-efficiency are prone to using unconventional means of power assertion (Archer, 1994). Same-sex couples often share equal power in the relationship, but one partner may be more dependent or vulnerable to violence when perceiving a lack of power (KcKenry et al., 2006). Individuals with

low self-esteem have been found to have higher risk of alcohol and drug use; furthermore, the incidence of IPV has been found to be highly correlated to substance abuse (Gelles, 2000). From the disempowerment standpoint, low self-esteem represents worthlessness and powerlessness. Same-sex IPV may derive from the perception of the lack of power (mental and physical control), rather than actual power.

Power management in the traditional heterosexual relationship is organized into two basic principles. They are the division of labor based on gender and male dominance in decision-making authorities (Peplau & Fingerhut, 2007). Same-sex couples are often in dual-earning relationships and each partner has some measures of economic independence. Kurdek (2005, p.252) concluded, same-sex couples "are more likely to negotiate a balance between achieving a fair distribution of household labor and accommodating the different interests, skills, and work schedules of particular partners." Equal power distribution in same-sex relationship does not safeguard partners against IPV. Same-sex couples disagree about similar topics such as finances, affection, criticisms, and household tasks (Metz et al., 1994). Furthermore, the cycle of escalating abuse in same-sex relationships may lead to "intimate terrorism" where one partner makes all the decisions for the other partner (Johnson, 2006). A study in interpersonal communication found that same-sex partners use more positive communication styles than did heterosexual couples (Gottman et al., 2003). However, as interpersonal conflicts escalate to emotional and physical aggression, the partners' ability to resolve conflicts diminishes (Stacey et al. 1994).

2.4 Similarities and Differences between Same-Sex and Heterosexual Relationships

Regardless of sexual orientation, same-sex couples value affection, shared interests, dependability, and similar religious beliefs as much as heterosexual couples (Paplau & Fingerhut, 2007). However, gay men place greater emphasis on physical attractiveness and lesbians more on personality characteristics (Paplau & Fingerhut, 2007). Similar to heterosexual couples, same-sex individuals meet potential dates via friends, bars, and social events (Bryant & Demian, 1994). The Internet has also become a popular venue for dating and socialization—with rates similar for both gay and heterosexual populations (Klinkenberg & Rose, 1994).

For same-sex relationships, the boundaries between friendship and romantic relationships is particularly complex (Nardi, 1999). In recent studies, same-sex couples are likely to remain friends with former sexual partners (Solomon et al., 2004; Weinstock, 2004). In addition, same-sex individuals are more likely than heterosexuals to agree to "remain friends with someone whom I've had a serious relationship" (Harkless & Fowers, 2005). The potential negative consequence for same-sex IPV victims may be future episode(s) by the past abuser.

2.5 Legal Protection

Until the recent Supreme Court decision in *Lawrence v. Texas,* 13 states had sodomy statues in their legislation. These laws deter same-sex IPV victims from reporting violence through penalties for violation ranging from fines to imprisonment (Mauro, 2002). The statues also criminalized oral and anal sex between consenting adults even in the privacy of their own homes. On June 26, 2003 the Supreme Court struck down the Texas law and precluded the government from intruding on the personal and private life of the individuals, regardless of

sexual orientation (Rivera, 1991). One reason why same-sex IPV statistics have been low may be due to the fear of punishment by law.

While police departments have been ineffective in the prevention of same-sex IPV; they may have played a role in perpetuating institutionalized homophobia (Rezetti, 1992). Often times, police arrive at the scene (when reported) and cannot figure out who is the abuser and who is the victim. As a result of the inability to identify the victim/abuser, both parties are either arrested or left to "work things out" (Hodges, 2000). Jeffery Dahmer's ability to murder 17 people can be partially attributed to the police officers' lack of training in dealing with same-sex IPV.

2.6 Barriers to Reporting

Members of the same-sex relationship community face a number of unique challenges in accessing IPV-related services (McClennen, Summers, & Vaugh, 2002). Victims of IPV are often hesitant to seek help because of institutionalized and internalized homophobia (Peterman and Dixon, 2003).The "moral closet" trivializes the gravity of same-sex IPV (Brown, 2008). In addition, the nature of the abuse and the perceived lack of useful resources continue to discourage victims from reporting violent events (Balsam et al., 2005). Research has found same-sex victims most often seek support in their friends (McClennen et al., 2002) instead of seeking formal sources such as attorneys and shelters. The implication of the inability to receive helpful guidance contributes to the victims remaining silence about their abuse (McClennen, 2005).

Additional stressors such as the power of outing and stereotypes can deter IPV reporting. As mentioned earlier, abusers in the same-sex relationship uses outing or divulging a partner's

sexual orientation to family, friends, and employers in attempt to keep the victims from reporting and remaining in the abusive relationship (Aulivola, 2004). Stereotypes such as "abuse in same-sex relationship is usually mutual" perpetuates the cycle of violence. Study of the reciprocity of violence in same-sex IPV suggested non-mutual aggression; one partner is consistently the primary aggressor (Letellier, 1994). These stressors are not present in heterosexual relationships and may include social norms that condone physical violence between men as a form of defense (Island & Letellier, 1991).

Another explanation of under-reporting same-sex IPV is community preservation. The "denial, minimization, and rationalization of the gay community is a way of protecting itself from a society that is looking for reasons to condemn lesbians and gays as sick and perverted" (Wilson, 1997, p.118). Aulivola (2004) further explains survivors of IPV are not willing to employ the criminal justice system because the police record would jeopardize the abuser's standing in the community. Current research of IPV indicated no significance of medical visits between abused and non-abused men (Houston & McKirnan, 2007). This study suggests cultural and institutional barriers prevent abused men from obtaining assistance. One explanation of the barrier is because many agencies are not prepared to assist men (Merrill & Wolfe, 2000).

Chapter III

METHODS AND PROCEDURES

3.1 Context of Study

An anonymous, cross-sectional survey design was used to conduct this study (Appendix A). Given the exploratory nature of focusing IPV research on a relatively unknown study group—gay men—the study was developed to assess the feasibility of recruiting 100 participants who met eligibility criteria. The study was administered using an electronic platform—Psychdata—which is an academic version of Survey Monkey that operates without any commercial sidebars.

The eligibility criteria for study participation included the following characteristics: participants had to be gay men currently living in Atlanta, Georgia. The recruitment of the participants was based on convenience sampling using a popular social media outlet: Facebook. First, a mass e-mail was sent via Facebook to all participants attending an event specifically created by the Principal Investigator [PI] to launch the study. The invitation language is contained in Appendix B. The survey link was embedded within the electronic event. Interested participants had to review the approved consent (Appendix C) and click to continue with the survey if they wished to continue and participate in the study. The e-mail invitation also encouraged participants to forward the invitation to other potential candidates—therefore, a

snowball methodology of recruiting study participants was also employed (Appendix D). The Institution Review Board (IRB) had approved this study prior to the Facebook survey invitation (Appendix E).

3.2 Study Instrumentation

The study survey consisted of 49 items and used both PI-created questions, as well as utilized a validated instrument—the Partner Abuse Scale—Physical (PASPH). Hudson created the PASPH in 1997 and its psychometric properties indicate that it is a highly reliable scale (reliability coefficient of .9). Demographic items that were developed by the PI included variables to capture participants' age, ethnicity, and educational attainment. Further, questions relating to risk taking behavior such as alcohol and drug use and safe sex practices were included. Additional questions regarding perceptions of violence within the Atlanta, gay male community were posed.

Once 100 surveys were completed, the survey was officially closed and the online event was removed. Data was downloaded from the Psychdata server and imported into SPSS—the Statistical Package for Social Sciences, Version 18.0 (Chicago, IL, www.spss.com). Descriptive statistics were run to summarize the demographic profile, behaviors, perceptions, and reported abuse among the sample. Chi-square tests were run to see how personal characteristics associated with reported IPV—using items from the PASPH scale.

CHAPTER IV

RESULTS

This chapter is dedicated to presentation of the study findings—specifically in relationship to the original research questions:

1. How does education level correlate with reported physical IPV among the study sample?
2. Does disclosure status of participants significantly relate with positive reports of IPV?
3. How does age associate with reported physical IPV among the study sample?
4. How does alcohol or other substance use associate with reported physical IPV among the study sample?
5. How does ethnicity associate with reported physical IPV among the study sample?

4.1 Findings of Demographic Profile

The PI was successful in obtaining 100 surveys within a 16-day data collection time frame. The age, ethnicity, orientation status, and educational attainment distribution of the sample is presented in table 4.1. The majority (70%) of the participants in this study sample falls in between the age range of 22 to 45 years. Fifty-five percent graduated from college and 33% are either in college or had some college experience. Ethnicity was dichotomized into two categories to show distinct comparison (white compared to non-white). Seventy-three percent of the participants identified themselves as having a disclosed orientation status.

Table 4.1 Demographic Profile of Study Sample (N=99)

Demographic Characteristics	Percent
Age	
21 and Under	11
22 to 33	34
34 to 45	35
45 and Above	20
Educational Attainment	
High School or Less	12
Some College	33
Graduated from College	27
Post Graduate School	28
Ethnicity	
White	62
Non-White	38
Orientation Status	
Disclosed	73
Non-Disclosed	27

4.2 Findings of Substance Taking Behaviors

Table 4.2 presents a summary of findings related to risk taking behaviors among the study sample. It includes data on the use of alcohol, tobacco, prescription, and other illicit drugs. Although 71% of the study sample reported never/ 0 days of alcohol consumption in the last 30 days, 29% reported consumption. Nine percent reported alcohol consumption of 21 days or more. Eighty-eight percent of the participants smoked within the last 30 days; and 18% smoked 21 days or more. Forty-four percent of the participants took prescription drugs and 19% took illicit drugs.

Table 4.2 Substance Taking Behavior Summary

Substance	Percent
Alcohol (N=98)	
Never/ 0 Day	71
1-5 Days	8
6-10 Days	6
11-20 Days	6
21 Days or More	9
Tobacco (N=99)	
Never/ 0 Day	12
1-5 Days	30
6-10 Days	17
11-20 Days	23
21 Days or More	18
Prescription Drugs (N=99)	
Never/ 0 Day	56
1-5 Days	13
6-10 Days	6
11-20 Days	5
21 Days or More	20
Illicit Drugs (N=99)	
Never/ 0 Day	81
1-5 Days	13
6-10 Days	3
11-20 Days	0
21 Days or More	3

4.3 Findings of Dichotomization in Substance Taking Behavior

Table 4.3 dichotomized the results into two categories: yes or no. This table provides distinction between participants who engage in substance taking behavior and those who do not.

Table 4.3 Dichotomization of Substance Taking Behavior

Substance Dichotomization	Number of Participants
Alcohol (N=99)	
Yes	89
No	10
Tobacco (N=98)	
Yes	28
No	70
Prescription Drugs (N=99)	
Yes	44
No	55
Illicit Drugs (N=99)	
Yes	19
No	80

4.4 Findings in the Perceptions of IPV

Table 4.4 presents the perception of IPV in Atlanta, Georgia among study participants. Sixty percent of the study sample believed IPV is a health issue in Atlanta and 66% reported that they know other gay couples, currently or in the past, in relationships that involve IPV.

Table 4.4 Perceptions of IPV in Atlanta

Perceptions	Percent
Intimate Partner Violence Is a Health Issue (N=96)	
Yes	60
No	40
Knowledge of Other Gay IPV Relationships (N=99)	
Yes	66
No	34

4.5 Findings of Reporting Categories

Table 4.5 represents a summary of the 6 categories of individuals/agencies to which in an event of IPV took place—to whom they would report. Respondents were allowed to select

multiple categories. The top three outlets, in descending order, that respondents indicated they would report to included: friends, family and police.

Table 4.5 Reporting Categories of IPV

Reporting Categories	**Percent**
No One	
Yes	27
No	73
Friends	
Yes	55
No	45
Family	
Yes	37
No	63
Police	
Yes	33
No	67
Professional counselor	
Yes	12
No	88
Other	
Yes	5
No	95

4.6 Findings of Perpetration

Tables 4.6 present the summary reports of IPV perpetration and among the study sample. Perpetration was indicated if any positive report of delivering physical harm to his partner was obtained. The summary of perpetration reported by study participants is presented Table 4.6.

Table 4.6 IPV Perpetration Summary

Perpetration of IPV	Number of Participants
Physical Harm (N= 99)	
Yes	18
No	81
Threatened to hurt with the use of words, gestures, or weapons (N=99)	
Yes	12
No	80
Other	7
Forced Sex (N=98)	
Yes	5
No	93

4.7 Findings of Victimization

Victimization of IPV was indicated if respondents positively responded that they received any harm directed to the respondent that was initiated by their significant other (same-sex partner). The summary of the top four types of reported victimization reported by study participants are represented in Tables 4.7.

Table 4.7 IPV Victimization Summary

Victimization of IPV	Number of Participants
Beats me when he drinks (N=97)	
Yes	27
No	70
Punches and shoves me around violently (N=97)	
Yes	23
No	74
Hits and punches my arms and body (N=96)	
Yes	21
No	75
Slaps me around my face and head (N=97)	
Yes	18
No	79

4.8 Findings of IPV Reported by Demographic Characteristics

Table 4.8 represents the mean and range of IPV scores by age, educational attainment, ethnicity, and disclosure status. The calculations of the IPV scores were based on the WALMYR Assessment Scales (Hudson, 1992). The range of scores was from 0 to 100, with higher scores being indicative of a greater magnitude or severity of IPV. For analytic purposes, ethnicity was dichotomized to white and non-white.

Table 4.8 IPV Scores by Demographic Characteristics

Demographic Features	**IPV Average Score (Range)**
Age	
21 and Under	.44 (0-4.00)
22 to 33	4.32 (0-42.00)
34 to 45	4.97 (0- 24.67)
45 and Above	3.53 (0-32.00)
Educational Attainment	
High School or Less	5.81 (0-23.33)
Some College	3.56 (0- 42.00)
Graduated from College	2.28 (0-24.67)
Post Graduate School	5.36 (0-32.00)
Ethnicity	
White	3.35 (0-42.00)
Non-White	4.20 (0-24.67)
Orientation Status	
Disclosed	4.69 (0-42.00)
Non-Disclosed	2.35 (0-20.77)

4.9 Findings of Prevalence of IPV by Key Independent Study Variables

In order to determine if demographic characteristics were associated between reported violence, Chi-Square tests were run. Any positive report from the 25 PASPH scale was coded positive for IPV and this outcome variable was tested for associations with educational attainment, orientation status, age, and ethnicity. Table 4.9 presents complete results.

Table 4.9 Prevalence of IPV by Key Independent Study Variables

Demographic Features	**% Positive IPV**	**p- values**
Ethnicity		
White	25.5	.024
Non-White	48.6	
Education		
Some College and Below	28.2	.276
College Graduate and Beyond	39.2	
Age		
21 and Under	11.1	.120
22 to 33	48.3	
34 to 45	36.4	
45 and Above	22.2	
Orientation Status		
Disclosed	33.9	.773
Not-Disclosed	37	
Substance Use		
Yes	37.8	.04
No	0	

Therefore, these results address the initial study research questions. The first considered how educational attainment correlated with reported physical IPV among the study sample. Whereas the IPV prevalence rate among those having lower educational attainment (some college and below; 28%), and those having a minimum of a college education reporting greater rates of IPV (39%), these results were not found to be statistically significant. For disclosure status—results indicate that 37% of those who are not openly gay report positive IPV, whereas disclosed participants had slightly lower IPV rates (34%). This was not found to be a significant association. The third research question examined if age was associated with positive IPV. The prevalence of IPV was most prevalent among participants between the ages of 22 and 45. This

age range represented two-thirds of all reported IPV among the study sample. However, the Chi-Square test did not reveal this relationship to be statistically significant (χ^2 (3) = 5.835, p<0.120). The fourth research question examined if any substance use (reported alcohol, tobacco, or illicit drug use) was associated with positive IPV. Results indicate that all reported IPV was associated with participants indicating that they use substances (38%). This was found to be a statistically significant association (χ^2 (1) = 4.061, p=0.04). The final research question examined association of IPV with ethnicity. In this study sample, 25.5% of Whites surveyed had experienced some form of IPV, as compared to 48.6% of non-whites. The difference in IPV prevalence between Whites and Non-Whites were significant as indicated by the Chi-Square analysis (χ^2 (1) = 5.062, p=0.024).

4.10 Findings of Demographic Characteristics Associated with IPV

Finally, when Chi-Square tests were run on individual PASPH scale items with select independent variables, there were a number of significant relationships detected specifically among Non-White participants and those who indicated that they were not openly gay. Significant items are presented in Table 4.10.

Table 4.10 Significant IPV and Demographic Characteristic Associations

Demographic Features	**p- values**
Non-White Ethnicity	
My partner threaten me with a weapon	.002
My partner twists my finger, arms, or legs	.011
My partner pinches or twist my skin	.026
My partner hurt me while we are having sex	.048
My partner pokes or jabs me with pointed objects	.013
Non-Disclosed Orientation Status	
My partner beats me so hard I must seek medical help	.041
My partner beats me when he is drinking	.049
My partner throws dangerous objects at me	.014

CHAPTER V

DISCUSSION AND CONCLUSION

5.1 Complexities of IPV in Male Gay Relationships

It is only within the last decade that violence prevention programs, specifically those targeting the LGBT audience, have raised the gravity of this public health issue. Gay IPV is particularly difficult to identify because of the various degrees of violence and the types of violence that is delivered. Although this study measured physical violence, other types of violence such as mental, emotional, and psychological violence may exist within our sampled population. Participants' perspectives on the perpetrator-victim spectrum may vary depending on personal, contextual circumstances. For example, the victim in a relationship may control the financial resources, but the perpetrator holds the informational "currency" such as partner's undisclosed status. This dynamic may fluctuate once the partner's status is disclosed or the financial resources change.

Societal stereotypes also add an additional complexity to this study. Perpetual myths around gay male experiencing IPV belittle the severity of this public health issue. The first myth involving gay male IPV is that it is a fair fight between two equals. This myth portrays both male as the perpetrators and fail to validate the victim. Victims do not have to be hit to suffer the mental consequences of violent abuses. The second myth is that gay male IPV is "boys being

boys." This myth acknowledges and accepts societal attitude toward male violence. As a consequence of this myth, victims often remain in the abusive relationship and do not seek counseling on what they perceive as "normal". The third myth is "It's just a lovers' quarrel". Physical violence is not a quarrel, but rather delivering harm to another individual. The third myth undermines the complexities surround gay IPV. As recognized in the scientific literature, gay male IPV has an additional dimension of the "moral closet." Victims may remain in the abusive relationship in order to save-face or avoid shame. The rite of passage in "coming out" is a gradual and many time a painful process. Unfortunately, youth and adults sometime chose suicide as a mean to resolve their issues.

5.2 Discussion of Research Questions

The main research question from the analysis was to examine the extent to which IPV occurs in our samples and their willingness to report. It was clear from the analysis that positive IPV scores exist in the sampled population. In addition, study results highlight significant associations between demographic characteristics and risk taking behaviors that can be insightful for taking action to address this problem moving forward. In fact, knowing that substance use and ethnicity are associated with increased IPV provides insights into how public health professionals can target specific subgroups of Atlanta's gay community. The following paragraphs will discuss each of the research questions separately.

The first research question is how does education levels correlate with reported physical IPV among the study sample. Higher education level provided some types of protective barrier against reported IPV. The results of this study found that those who finished college has a lower range of IPV scores overall. College graduates may have learned interpersonal or conflict

management skills which allow for positive outcomes in the conflict resolution process. In additional to the learned skills, participants with higher education may have better support group, financial resources, and/or access to professional counselors to mediate relationship issues. However, educational attainment was not found to be significantly associated with positive IPV. One explanation is perhaps the added stress of achievement negates any protective advantage education usually affords when violence occurs in the studied populations.

The second research question examined disclosure status with IPV among study participants. Results from this study did not find significant association between orientation status and reported IPV—when individual PASPH items were statistically tested. Many reasons contribute to the inconclusive finding that IPV is associated with disclosure status. First, many men may not be open about their orientation status. One partner may be openly gay while the other is not. This orientation dynamic can create a power imbalance which ultimately intensifies violent behaviors. An example would be one partner threatening to "out" the other. The "closeted" partner may then threaten to physically harm the other. As a result of this interaction, the pendulum of perpetrator-victim role can reverse depending on the situation. This vicious cycle can contribute to greater turmoil, anxiety, and depression. Substance taking behaviors may be further exacerbated in situations involving IPV. Victims and perpetrators can turn to prescription drugs as a way of coping; furthermore, the possibility of engaging in illicit drug may be more likely to occur. Continued research that delves further into how disclosure may or may not be linked with IPV (whether as perpetrator or victim) is warranted.

The third research question is how does age associate with reported physical IPV among the study sample. Age was not found to be significantly associated with IPV in this study. Analyses indicate that the prevalence of IPV was greatest for participants ages 22 through 45.

Further research attention directed towards the psychology and sociology of this population during these important decades of development would help shed light on explanatory variables that may lead to increased violence during this time period. One reason may be that young adults (ages 22 to 33) may be building conflict management skills unique to gay populations at this time. While it in this study it was found that those ages 21 and under had the lowest level of reported IPV, this may be attributed to the fact these men may be dealing more with coming to terms with their sexuality—versus addressing relationship-building issues. Again, further focus and research examination across disciplines would lend insight into how age and IPV differs across the lifespan.

The fourth research question explored the association between substance use (alcohol, tobacco, and illicit drugs) and IPV. Results demonstrated that when all PASPH items were recoded into a single indicator—all reported IPV cases included either victims or perpetrators that reported substance use. Clearly, violence and substance use are linked. Our finding is consistent with the National LGBT Tobacco Control Network, which estimated that LGBT have 40 to 200 % higher smoking rate (due to stressors) than heterosexual people (2011). In future studies, examining the type, frequency, and nature of substance abuse, in light of violence must be explored. As previously mentioned, this population experiences extreme forms of societal stress and using substances is one mechanism of coping. These study findings align with the previous research that indicates substance abuse among the gay population is prevalent and linked to a range of unhealthy conditions, including violence.

The final research question examined ethnicity and its association with reported physical IPV. An association between ethnicity and types of violence inflicted by partner was found. A higher proportion of men who self identified as belonging to a race other than white, reported

higher average IPV scores. Barriers such as the inability to speak English, inaccessibility to information, and low socioeconomic status may have undermined one's ability in dealing with IPV. Cultural differences, such as saving-face and emphasis on group collectivism, may also have contributed to the high level of average IPV score in the non-white category. Cultural norms (i.e. shaming the community/family) may have indirectly coerced individuals to linger in the abusive relationship. Public health programs need to be able to understand how ethnicity and cultural context influence IPV identification, as this is a critical benchmark of understanding necessary for the development of effective programs for reporting, resolution, and prevention of IPV among the gay community in Atlanta.

5.3 Implications of Findings

In considering the overall demographic characteristics of the sample, the findings from the survey found that 88% of the participants attended college. In comparison, only 71% of the sample indicated that they were openly gay/or disclosed in their sexual orientation status. These two characteristics may have contributed to the significant reports of IPV incidents. McClennen et al. (2002) found that closeted gay men have a higher prevalence of IPV. Ethnicity (white vs. non-white) in this study does appear to be associated with the incidents of IPV; however, this is inconsistent to Green et al.'s finding (2002). The findings from this study demonstrate important societal implications, particularly for IPV among the gay community. Results of this pilot research study indicate that IPV is a prevalent issue and is linked strongly with substance use. There is a need to move forward and explore additional risk and protective factors associated with IPV within Atlanta's gay community in a more robust scientific manner.

Another implication from this study is the acknowledgement of IPV as a public health issue. A majority of the participants agree that IPV is a public health issue facing gay men in Atlanta; moreover, 65% of the participants have knowledge of other people engaged in IPV. In this study, the perpetrator of IPV did not have a significant higher score than those of the victims. However, some participants did include other means of IPV not listed on the study survey. Among the most graphic responses were "I told him I would run him over with his car" and "push him down the stairs." Although a public health issue, participants' overall reporting of IPV was low. It is no surprise that the majority of the participants select "friends" as the category of reporting IPV. This finding is consistent with McClennen et al. (2002) in that most IPV victims seek support from friends rather than formal (attorney or shelters) supports.

5.4 Study Strengths and Limitations

The PASPH instrument used for this study was the strength of this study. The psychometric property of the instrument is highly reliable (reliability of .9) and has been used for many social science research studies. The study design of using Facebook allowed for a greater sampling of participants living in the Atlanta area. Due to this sampling methodology, it allowed the researcher to reach a fairly disperse audience, and enroll participants representing various ethnic backgrounds, sexual orientation status, ages, and risk taking behaviors. Another, strength of the study is that the responses were anonymous and confidential allowing the responses to be more valid. The survey was easily administered and allowed for a wide variety of subject areas to be covered.

One limitation from the analysis is that the results are not generalizable. The responses all came from gay men in the State of Georgia and only from participants who have access to

Facebook. For example, these results are not generalizable to gay men who live on the Western (i.e. San Francisco or Los Angeles) portion of the United States. Participants living in that area of the country may have different demographic features or risk taking behaviors that would yield different outcomes. Another, limitation of the study is that not all gay men living in Atlanta were surveyed. Instead, only a certain percentage of the population was used, because this is a sample, and not a census. Since our simple size was 100, the results may be skewed.

Another limitation of the demographic category is that the ethnicity categories were narrowly defined, and did not include a bi or multi ethnic category for participants of more diverse backgrounds. Another consideration for this demographic feature is that some participants may not define their race and ethnicity the same nor understand the concept of ethnicity as social construct of society.

Lastly, it is important to consider the intensity of IPV reports within the study. Participants may undermine the severity or disregard IPV incidents due to personal experiences. Some may consider IPV as an "accident" when in actuality it is an assault. Therefore, results may conclude higher or lower findings in comparison to actual events. In general, participants' perception on intensity may be problem for studies in general. Balsam et al. (2005) indicates that gay men are more hesitant in reporting incidences of IPV. Peterman and Dixon (2003) attributes this behavior as the "moral closet" dilemma in which the gravity of same-sex IPV is trivialized by institutionalized or internalized homophobia.

5.5 Recommendations and Prevention Strategies

While the focus of this thesis was directed at gay male IPV and better understanding of their willingness to seek supports in situations it does not negate the importance of strong prevention efforts. In fact, prevention is the key in dealing and reducing the severity of IPV prevalence. In the next few paragraphs, a variety of prevention strategies and evidence-based research methods that can be effective in addressing gay male IPV in Atlanta, Georgia will be discussed. These strategies are also important because they address IPV on intrapersonal, interpersonal, and community levels of physical violence prevention.

The first of these is utilizing the 4-step approach recommended by the CDC (2011). The first step in the prevention of IPV is to define the issue and see how big the issue is. This can be applied to individuals, between partners, and communities. In addition to defining the issue, where, and whom it affects should also be addressed. An individual can evaluate his current and/or past relationships and identify if there is/was IPV involved. The individual can seek counseling or learn skills in preventing future occurrences. Couples may also seek counseling or take classes together. This is only feasible if the partners acknowledge the problem and is willing to work on the issue.

Step 2 is identifying the risk and protective factors. In other words, why is IPV occurring and can the risk factors be reduced? In this step, one should look at factors, such as alcohol use and SES, attributing to the issue. Identifying why this public health issue occurs is the key in developing the prevention program. An individual or couple may enroll in an Alcohol Anonymous program or Anger Management course. Again this is dependent on the willingness of an individual to seek help. At the community level, a prevention program developer would

research and evaluate the community's risk and protective factors. After all the information has been gathered then prevention program(s) may be implemented.

The last two steps are application and execution at the community level. Step 3 involves developing and testing prevention strategies. IPV prevention programs such as outreach and awareness campaigns can be used to address the issue. For example, YouthPride, an LGBT non-profit group in Atlanta, provides weekly workshops on topics such as violence preventions and "teen-talks". Step 4 assures the widespread adoption of the best-practiced programs. This allows for the sharing of information on prevention program that works and what did not. Furthermore, encouragements are given for the adaptation of the prevention program(s). For example, CDC provides funding or technical expertise for communities who would like to adopt the recommended benchmarks.

The second recommended prevention strategy is to promote the use of the State of Georgia's emergency hotline through a health communication approach. The 24- hour statewide hotline 1-800-33-HAVEN or 1-800-334-2836 hotline allows individuals to call anonymously and confidentially to make a report of abusive relationship. AIDS Atlanta and YouthPride are two Atlanta based organizations that utilize the "call-a-buddy" program that provide assistance for callers. The callers will receive information on local counseling centers and other information regarding support groups. The hotline can be posted around targeted locations (bars, clubs, and community centers). The emergency number allows individuals to report cases of IPV without the fear of retaliation or punishment. Furthermore, it provides documentation for incidents that are reported. The hotline serves as a strong prevention method to encourage reporting of incidents that could reduce the incidents of IPV.

The last strategy is to begin a community partnership on addressing IPV prevention. Atlanta has many small non-profit LGBT organizations. Each organization can include web resources on their website. In addition, the organizations can post specific meeting times on IPV discussion groups. If resources allow, the local organizations can provide brief, interactive courses on conflict management, anger management, and inter/intrapersonal communication. Providing useful resources and specific skills can potentially reduce the risk factors of IPV. Raising awareness and discussing constructive methods of dealing with physical IPV is the key to prevention. The main advantage of a community partnership is to maximize the resources while reduce/share costs. Local organizations may achieve better results by collaborating on one public health issue: IPV.

5.6 Future Areas of Research

Intimate partner violence is a complex and multi-layer issue. This study clearly does not begin to understand the complexities surrounding IPV. Since this study focused primarily on physical violence, future research may include psychological and sexual abuse of IPV. Unlike physical violence that is visible, psychological and sexual abuse can be more traumatic and less obvious. Sexual abuse can potentially lead to depression and other mental disorders; moreover, the risk of contracting HIV is greatly increased (Stall et al., 2003). Psychological abuse can have long-term and short-term effects. Victims may not realize the damage of short term abuse (believing he will change and disregard any future occurrences) until long-term harm has been done (inability to form health relationships with someone else in the future). Future study should also measure the intensity of IPV. The duration and frequency of the episodes may provide additional insight to the dynamics of IPV.

Additionally, qualitative research can provide greater depth on this issue. The qualitative analysis can provide content analysis and perhaps ethnographic information on the victims and perpetrators. Conducting a research interview or focus group may capture information that cannot be capture with quantitative methodology. For example, a person who identified himself as a victim may be the perpetrator at another time. The perpetrator may have retaliated as a mean of self-defense. The parties may have dual roles, but this can only be clarified with an interview. Formal interviews of former victims/perpetrators can provide a different perspective on why the episode occurred in the past. The victims/perpetrators can provide the solution or strategy they used to prevent future episodes.

5.7 Conclusion

Intimate partner violence continues to be a major public health issue. This health issues is even more severe in marginalized population such as the LGBT community. Although this study utilized one of the most prominent social network website, Facebook, it only captured a small portion of the population in Atlanta, Georgia. However, this study is a start in finding out a major public health issue facing one of Atlanta's communities. Most of participants in this study agree IPV in a public health issue in the Atlanta gay community. More astoundingly, a majority of the participants know other people engaged in IPV. Prevention programs and raising awareness of IPV will be the key in reducing the risk factors of this public health issue.

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Appendices

A. Study Questionnaire

ZIP CODE OF RESIDENCE
What is the zip code of your residence (please type in the 5 digits)

___ ___ ___ ___ ___

PLEASE SELECT ONLY 1 ANSWER FOR THE FOLLOWING QUESTIONS:

1. Please select the race that best fits you:
    a. American Indian
    b. Asian
    c. Black or African American
    d. Native Hawaiian or Other Pacific Islanders
    e. White
2. What is your age range
    a. 21 and Under
    b. 22 to 27
    c. 28 to 33
    d. 34 to 39
    e. 40 to 45
    f. 46 to 51
    g. 51 and Over
3. What is the status of your sexual orientation
    a. Disclosed (Openly gay)
    b. Non-disclosed (Not openly gay)
4. What is your education level
    a. High School or Less
    b. Some College
    c. Graduated from College
    d. Post Graduate School (Master's and/or Beyond)
5. Do you know other gay (male) relationships that engage in Intimate Partner Violence?
    a. Yes
    b. No
6. Do you believe Intimate Partner Violence is a health issue in the Atlanta gay community?
    a. Yes
    b. No
7. Who would/did you report if/when Intimate Partner Violence occurred to you?
    a. No One
    b. Friends
    c. Family
    d. Police
    e. Professional Counselor
8. Has your intimate partner ever physically harmed you?
    a. Yes
    b. No
9. Has your intimate partner ever forced you to have sex?
    a. Yes
    b. No
10. Has your intimate partner ever threatened (use of words, gestures, or weapons) to hurt you?

a. Yes
b. No

PLEASE CHECK THE BOX TO TELL US HOW MANY DAYS, OVER THE PAST 30, YOU HAVE USED ANY:

11. Tobacco products (cigarettes, clove cigarillos, chewing tobacco, hookahs, etc):

Never/0 Days 1-5 Days 6-10 Days 11-20 Days 21 Days or More

12. Alcohol (beer, wine, and/or liquor):

Never/0 Days 1-5 Days 6-10 Days 11-20 Days 21 Days or More

13. Prescription Drugs (medication prescribed by a doctor):

Never/0 Days 1-5 Days 6-10 Days 11-20 Days 21 Days or More

14. Illicit Drugs (narcotics, cocaine, marijuana, meth, etc):

Never/0 Days 1-5 Days 6-10 Days 11-20 Days 21 Days or More

PLEASE SELECT A NUMBER BESIDES EACH OF THE FOLLOW QUESTIONS:

1 = Never
2 = Very rarely
3 = A little of the time
4 = Some of the time
5 = A good part of the time
6 = Very frequently
7 = All of the time

15. _____ My partner physically force me to have sex.
16. _____ My partner push and shove me around violently.
17. _____ My partner hit and punch my arms and body.
18. _____ My partner threaten me with a weapon.
19. _____ My partner beat me so hard I must seek medical help.
20. _____ My partner slap me around my face and head.
21. _____ My partner beat me when he is drinking.
22. _____ My partner make me afraid for my life.
23. _____ My partner physically throw me around the room.
24. _____ My partner hit and punch my face and head.
25. _____ My partner hit me in the face so that I am ashamed to be seen in public.
26. _____ My partner act like he would like to kill me.
27. _____ My partner threaten to cut or stab me with a knife or other sharp object.
28. _____ My partner choke or strangle me.
29. _____ My partner knock me down and then kick or stomp me.
30. _____ My partner twist my fingers, arms or legs.
31. _____ My partner throw dangerous objects at me.
32. _____ My partner bite or scratch me so badly that I bleed or has bruises.
33. _____ My partner violently pinch or twist my skin.
34. _____ My partner hurt me while we are having sex.

35. _____ My partner injure my genitals.
36. _____ My partner try to suffocate me with pillows, towels, or other objects.
37. _____ My partner poke or jab me with pointed objects.
38. _____ My partner have broken one or more of my bones.
39. _____ My partner kick me partner's face and head.

B. Invitation to Participate

You are invited to take a survey for a research study. The purpose of the study is to see if gay men in Atlanta, GA will complete an online survey about Intimate Partner Violence (IPV). You are invited because you joined the gay male living in Atlanta Facebook page. A total of 100 men will be recruited for this study. The survey takes 5-10 minutes to complete 39 items. The study will be open for one month from April 15, 2011 to May 15, 2011.

This questionnaire is designed to measure gay male Intimate Partner Violence (IPV) in Atlanta, Georgia. Intimate Partner Violence is defined as abuse that occurs between two people in a close relationship. The term "intimate partner" includes current and former spouses and dating partners. This survey will also measure the physical abuse you have delivered upon your partner. This is not a test, so there are no right or wrong answers. All your answers will be kept completely anonymous and confidential. The questions will take between 5-10 minutes and your participation is voluntary. Answer each item as carefully and as accurately as you can by either circling one of the choices or placing a number beside each one as follow.

C. Informed Consent

Georgia State University
Institute of Public Health

Informed Consent

Title: A Pilot Study of IPV among Gay Men in Atlanta Using Social Media

Principal Investigator: Dr. Sheryl Strasser
Student Principal Investigator: Ken Chen

I. Purpose:

You are invited to take a survey for a research study. The purpose of the study is to see if gay men in Atlanta, GA will complete an online survey about Intimate Partner Violence (IPV). You are invited because you joined the gay male living in Atlanta Facebook page. A total of 100 men will be recruited for this study. The survey takes 5-10 minutes to complete 39 items. The study will be open for one month from April 15, 2011 to May 15, 2011.

II. Procedures:

In order to take the survey, you will need Internet access. If you decide to take the survey, you will be asked to click on a link. There is no right or wrong answers. The survey data will be stored safely and no information to identify you will be asked. Once 100 surveys are complete, the link will be closed. This study tries to see if gay men will take a physical abuse survey online.

III. Risks:

In this study, you will not have any more risks than you would in a normal day of life.

IV. Benefits:

Completing the survey may not benefit you personally. Overall, we hope to gain information about physical IPV within the gay male community. The results will be used to see if a prevention program in Atlanta, Georgia is needed. This study may benefit society in understanding IPV among gay men.

V. Voluntary Participation and Withdrawal:

Taking the survey is voluntary. You do not have to be in this study. If you decide to be in the study and change your mind, you have the right to drop out at any time. You may stop participating at any time.

VI. Confidentiality:

The PI and Student PI will keep your records private to the extent allowed by law. Only Dr. Strasser and Ken Chen will be able to see survey data. While data sent over the Internet may not be secure, data is stored in a way that it must be decoded for use. No names, IP address, or identifying information will be collected. Data may be shared with those who make sure the study is done correctly (GSU Institutional Review Board, and/or the Office for Human Research Protection (OHRP) .

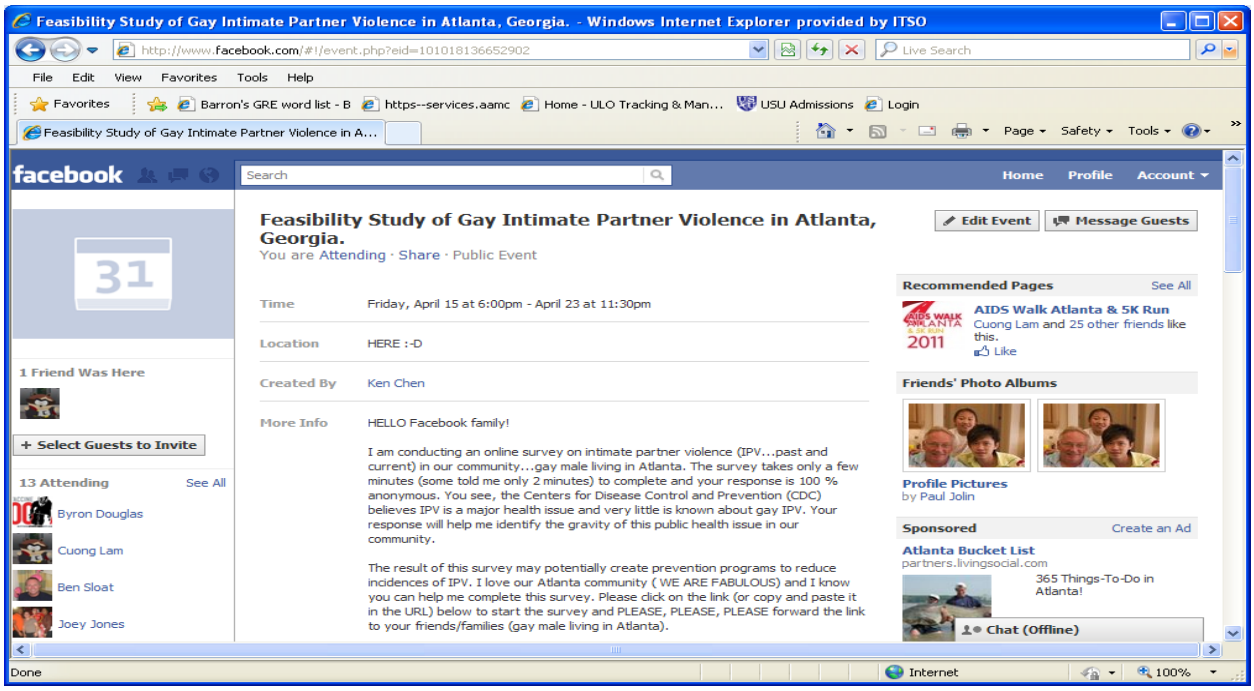
Information you provide will be stored on password and firewall protected servers and computers. The findings will be reported in group form.

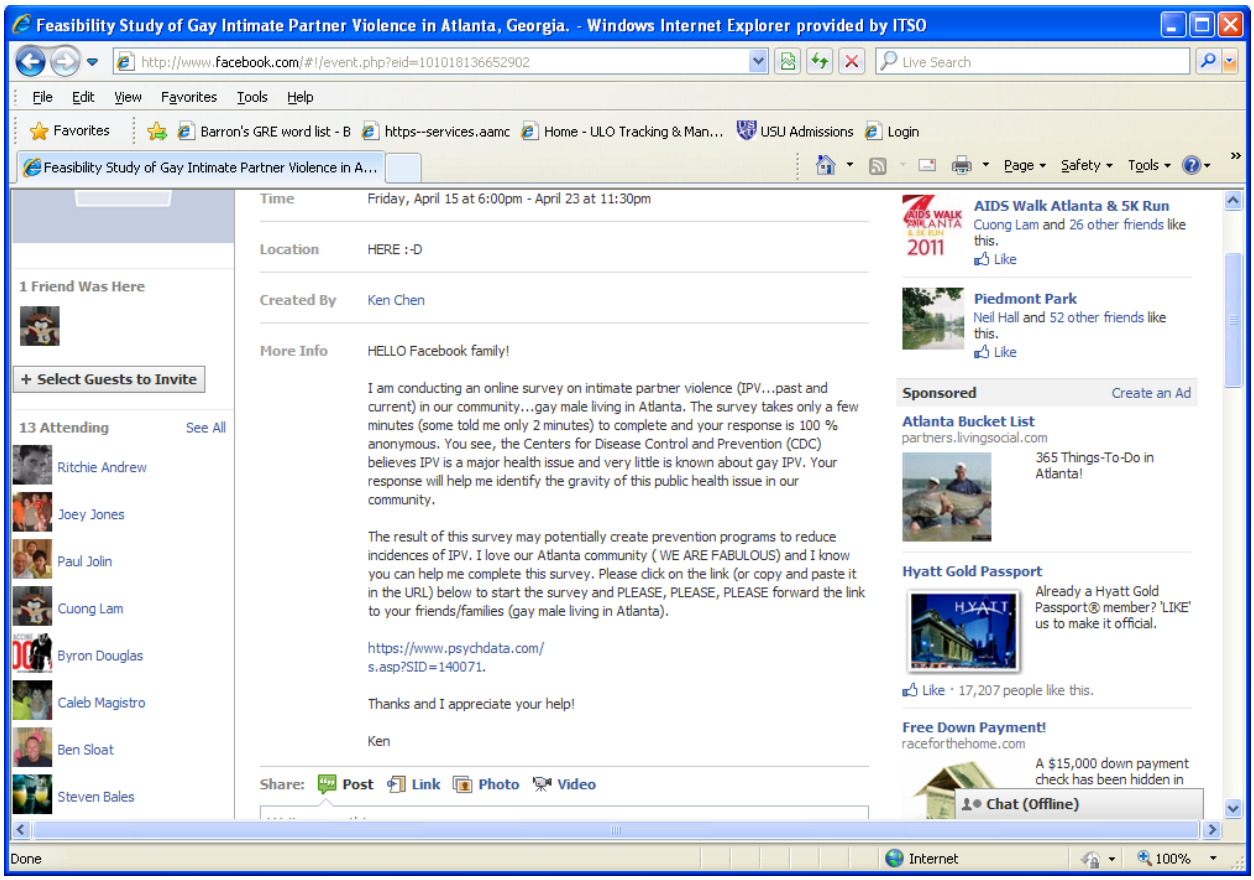
VII. Contact Persons:

Contact Sheryl Strasser at 404-413-1134 [sstrasser@gsu.edu] or Ken Chen at 770-309-7741 [ken1982chen@yahoo.com] if you have questions about this study. If you have concerns about this survey study, you may contact Susan Vogtner in the Office of Research Integrity at 404-413-3513 or svogtner1@gsu.edu.

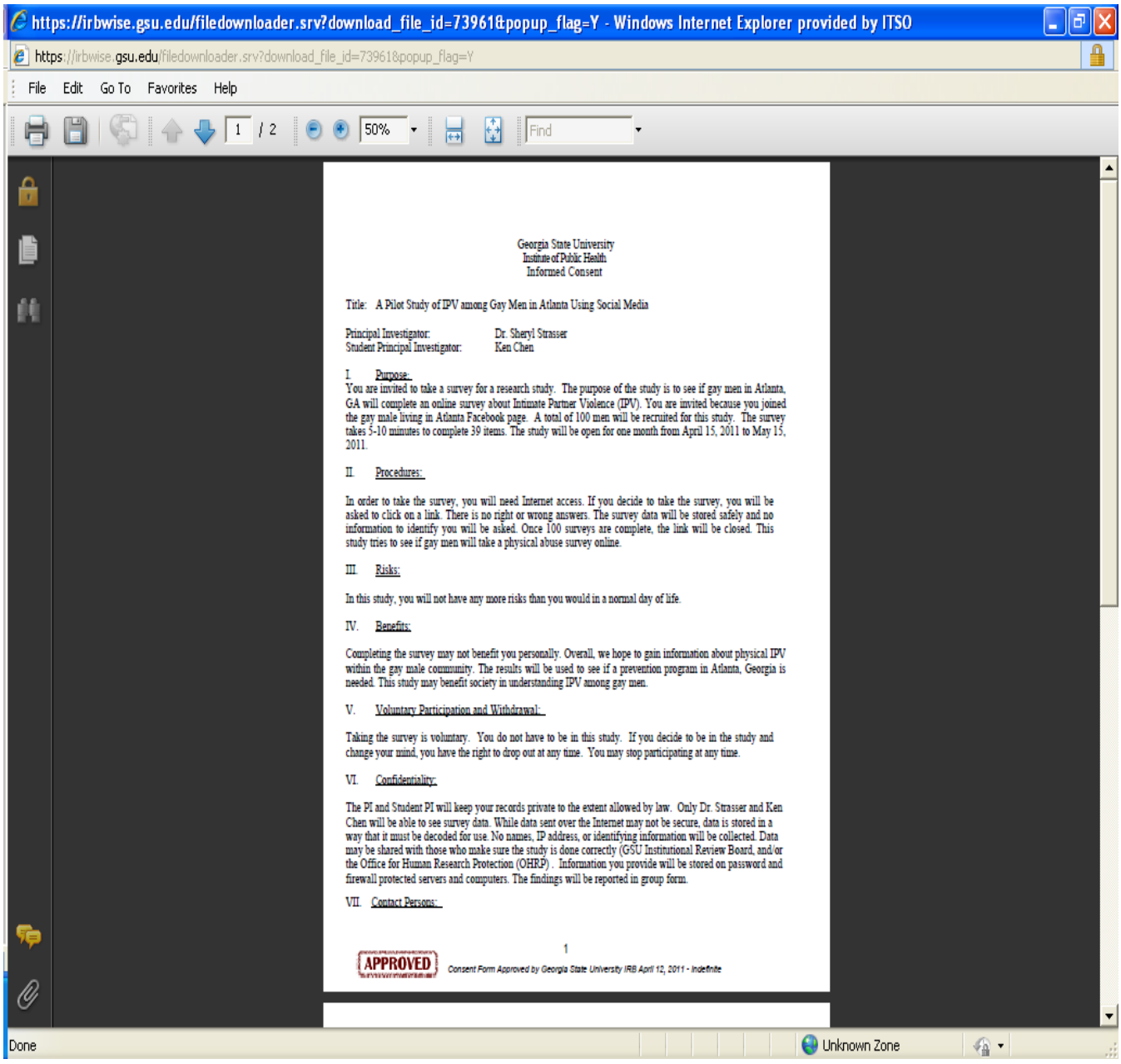
If you agree to participate in this research, please continue with the survey by clicking on the link below.

D. Facebook Screen Shots





E. IRB Approval



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VII. Contact Persons:

1

APPROVED Consent Form Approved by Georgia State University IRB April 12, 2011 - Indefinite

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https://irbwise.gsu.edu/filedownloader.srv?download_file_id=73961&popup_flag=Y

File Edit Go To Favorites Help

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2

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Done Unknown Zone