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J Interpers Violence published online 24 September 2012

DOI: 10.1177/0886260512459384

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Journal of Interpersonal Violence

XX(X) 1–10

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DOI: 10.1177/0886260512459384

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Abstract

Few studies have examined history of intimate partner violence (IPV) among sexual minorities. We assessed prevalence and predictors of IPV using a probability sample of California residents ages 18 to 70. Lifetime and 1-year IPV prevalence was higher in sexual minorities compared with heterosexuals but this was significant only for bisexual women and gay men. IPV of bisexual women, but not gay men, occurred in a heterosexual relationship. We tested whether the higher prevalence of IPV in gay men and bisexual women was explained by two mental health indicators—psychological distress and binge drinking—but this hypothesis was not supported.

Keywords

GLBT, domestic violence

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Despite receiving attention from lesbian, gay, bisexual, and transgender (LGBT) community organizations (e.g., *Anti-Violence Project*), few studies have examined histories of intimate partner violence (IPV) among sexual minorities. Studies have focused primarily on other forms of violence experienced by LGBT people, such as bias-motivated violence and bullying in schools (e.g., Gayes & Garofalo, 2012; Stotzer, 2012). Most available studies examining IPV among sexual minorities have relied on small, nonprobability samples (Burke, Jordan, & Owen, 2002; McClennen, Summers, & Vaughan, 2002; Murray & Mobley, 2009), of individuals recruited at LGBT community centers (Balsam, Rothblum, & Beauchaine, 2005), events (Balsam & Szymanski, 2005; Houston & McKirnan, 2007; Miller, Green, Causby, White, & Lockhart, 2001), through email lists (Balsam et al., 2005; Balsam & Szymanski, 2005), or through intimate partner violence helpline referrals and health clinics (Craft & Serovich, 2005; Heintz & Melendez, 2006; Miller et al., 2001; Merrill, & Wolfe, 2000). Using a probability sample, researchers in one study reported a higher prevalence of IPV in men in same-sex relationships than men in different-sex relationships, but similar histories of IPV among women in different- and same-sex relationships (Greenwood et al., 2002). In another study using the National Violence Against Women Survey, bisexual men and women reported the highest rates of IPV and incidents most often involved a different-sex partner (Messinger, 2011). Studies, including a 2010 policy brief analyzing the California Health Interview Survey (CHIS) data (Zahnd, Grant, Aydin, Chia, & Padilla-Frausto, 2010) and analysis of the 2005-2007 Behavioral Risk Factor Surveillance System survey (Blosnich & Bossarte, 2009), typically use either identity or behavioral definitions of sexuality but this can obscure important variability in IPV patterns among sexual minorities. Also in reports of history of IPV among LGBT individuals there is a presumption that the perpetrators of IPV are same-sex partners but this has not been assessed. Finally, studies have not assessed causes of sexual orientation disparity—that is, differences in history of IPV between sexual minorities (LGB) and straight individuals.

To address these gaps in the literature, we use a probability sample of California residents defined by mutually exclusive categories of sexual identity and behavior in men and women to provide population estimates of IPV. We assess the gender of the perpetrator of IPV to determine if IPV occurs in the context of same-sex relationships. We also test whether, psychological distress and substance use—potential risk factors for IPV (Testa, Livingston, & Leonard, 2003)—explain sexual orientation disparities in IPV where we find them.

Method

Sample

CHIS data were collected in 2007-2008. Surveys were administered through a computer-assisted telephone survey system and were conducted in five languages: English, Spanish, Chinese (Mandarin and Cantonese dialects), Vietnamese, and Korean. Most households were surveyed via a random-digit dialed landline telephone sampling frame geographically stratified by county; in addition, nearly 1,000 adults were contacted via a cell phone and another 1,000 households were oversampled from Los Angeles County. One adult from each household, chosen at random, was interviewed along with one child and one adolescent, if applicable (data on children are not relevant and not presented here). Information about CHIS methodology can be found at http://askchis.com/pdf/CHIS2007_method1.pdf

In total, 51,048 adults completed the survey, yielding a response rate of 52.8% for landlines, 52.0% for cell phones, and 69.0% in the Los Angeles area sample. The 2007 CHIS includes questions about sexual orientation and the sex of sexual partners in the past year (see Table 1). Only adults ages 70 or younger were asked to describe their sexual orientation, and only those adults ages 70 or younger who reported at least one sexual partner in the last 12 months were asked the sex of those sexual partners. Through these two questions respondents may be identified as lesbian, gay, bisexual, or heterosexual and as having only same-sex, different-sex, or both sex sexual partners in the past year.

Measures

Sexual orientation—Based on questions about sexual activity and sexual identity we categorized respondents in four mutually exclusive categories: Heterosexual, gay or lesbian, bisexual, and men who have sex with men (MSM) or women who have sex with women (WSW) who do not identify as LGB.

IPV—Respondents were asked if they had a history of IPV since age 18 (lifetime) and in the year prior to the interview (1-year). Intimate partner referred to current or past “husband, wife, boyfriend, girlfriend, or someone you lived with or dated.” Questions addressed being “hit, slapped, pushed, kicked, or physically hurt,” and “unwanted sexual intercourse, oral or anal sex, or sex with an object by using force or [threat] to harm.”

Mental health indicators—Respondents were asked a series of questions about their mental health and substance use. History of psychological

Table 1. Select Demographic Characteristics of California Health Interview Survey 2007-2008 Respondents by Sexual Orientation

	Women				Men			
	Heterosexual	Lesbian	Bisexual	WSW	Heterosexual	Gay	Bisexual	MSM
<i>N</i> (Unweighted)	16,926	267	247	94	13,447	415	135	92
% (Unweighted)	96.5%	1.5%	1.4%	0.5%	95.4%	2.9%	1.0%	0.7%
Education								
Less than a high school diploma	14.8% (.01)	6.9% (.03)	13.5% (.04)	34.8% (.11)	15.7% (.01)	8.3% (.03)	7.7% (.04)	3.4% (.03)
Graduate from high school	23.5% (.01)	14.6% (.03)	23.7% (.05)	26.4% (.09)	26.7% (.01)	18.0% (.05)	35.1% (.08)	30.4% (.13)
Some college	25.4% (.01)	24.7% (.05)	33.8% (.05)	11.3% (.04)	23.1% (.01)	25.8% (.04)	22.6% (.07)	33.3% (.09)
College degree or more	36.3% (.01)	53.8% (.06)	29.1% (.05)	27.6% (.07)	34.5% (.01)	47.9% (.05)	34.6% (.06)	32.9% (.08)
Race								
White	47.5% (.01)	64.1% (.06)	56.6% (.05)	52.2% (.10)	47.6% (.01)	53.7% (.05)	51.0% (.08)	42.2% (.10)
Latinos	22.6% (.01)	10.6% (.05)	16.1% (.03)	22.9% (.07)	24.0% (.01)	22.5% (.05)	18.2% (.07)	16.7% (.08)
Black	5.7% (.003)	8.9% (.04)	5.3% (.02)	7.2% (.03)	5.5% (.004)	6.2% (.03)	3.3% (.01)	1.2% (.01)
Other	24.1% (.01)	16.3% (.04)	22.1% (.05)	17.8% (.09)	22.9% (.01)	17.6% (.04)	27.6% (.07)	39.9% (.12)

WSW = women who have sex with women; MSM = men who have sex with men.

distresses was evaluated using the Kessler scale, which asks questions about feeling nervous, hopeless, restless, and depressed, among other things. Binge drinking variables were constructed using answers to questions about how many drinks a respondent usually drinks in one occasion. Women who consumed four or more drinks more often than once a month and men who consumed five or more drinks more often than once a month were coded positive for binge drinking.

Demographic Characteristics—Other variables that we considered as possible predictors of a history with IPV included self-reported race, educational attainment, age, and employment status.

Data Analysis

Sampling and replicate weights were used to account for the complex sampling design of the CHIS, and the jackknife repeated replication method was

used to obtain accurate estimates of the means and standard errors to represent California adults ages 18 to 70 who were asked sexual orientation questions.

Results

Table 1 shows demographic characteristics by sexual orientation for men and women separately. Among women, more lesbians were White and they had higher education than the heterosexual, bisexual, and WSW respondents. Among men, gay men had higher education but there was little variability by race/ethnicity.

Lifetime and 1-Year IPV in Women

Table 2 presents the unadjusted prevalence estimates and standard errors and adjusted logistic regression models for sexual orientation differences in women's history of lifetime and 1-year IPV. After controlling for race, educational attainment, age, employment status, binge drinking, and history of psychological distress, all three groups of sexual minority women had greater odds of having lifetime and 1-year IPV than the heterosexual women, but this was statistically significant only for bisexual women, who had more than 3 times the odds of having experienced lifetime IPV and 4 times the odds of 1-year IPV.

We tested whether sexual orientation IPV disparity can be explained by binge drinking and/or psychological distress. We found that, although both binge drinking and psychological distress were independently related to IPV, they did not explain the sexual minority disparity in lifetime or 1-year IPV. For example, daily or weekly binge drinking in the year prior to interview increased the odds of 1-year IPV (*OR*: 3.85; 95% *CI*: [1.87-7.96]), and low psychological distress decreased the odds of 1-year IPV (*OR*: 0.24; 95% *CI*: [0.18-0.32]), in the adjusted model but in testing mediation, the odds ratios for sexual orientation groups did not differ much in models with and without these risk factors (not shown).

Of the demographic characteristics included in the model, women with college education or more were less likely to experience lifetime and 1-year IPV (*OR*: 0.63; 95% *CI*: [0.47-0.85], *OR*: 0.53; 95% *CI*: [0.32-0.89], respectively) and, regardless of sexual orientation, compared with White women, Latinas were less likely to experience lifetime and 1-year IPV (*OR*: 0.58; 95% *CI*: [0.47-0.73], *OR*: 0.65; 95% *CI*: [0.42-0.98], respectively) and Black women were more likely to experience lifetime and 1-year IPV (*OR*: 1.48; 95% *CI*: [1.19-1.84], *OR*: 1.74; 95% *CI*: [1.07-2.82], respectively).

Table 2. Lifetime and 1-Year History of Intimate Partner Violence (IPV) Among California Health Interview Survey 2007-2008 Respondents by Sexual Orientation^a

	Women			Men		
	Unadjusted Prevalence	Effect of Sexual Orientation		Unadjusted Prevalence	Effect of Sexual Orientation	
	% (SE)	AOR (95% CI)		% (SE)	AOR (95% CI)	
<i>Lifetime IPV</i>						
Heterosexual	21.60% 0.01	1.0 (REF)		11.38% 0.00	1.0 (REF)	
Lesbian or gay	31.87% 0.05	1.23 0.79	1.94	26.94% 0.04	2.68 1.75	4.11
Bisexual	51.99% 0.05	3.24 2.20	4.77	19.57% 0.05	1.16 0.46	2.95
WSW or MSM ^b	32.11% 0.09	1.17 0.63	2.19	16.51% 0.07	1.65 0.68	4.00
<i>1-Year IPV</i>						
Heterosexual	5.00% 0.00	1.0 (REF)		4.64% 0.00	1.0 (REF)	
Lesbian or gay	10.23% 0.03	1.13 0.49	2.59	12.08% 0.03	2.41 1.32	4.40
Bisexual	27.48% 0.06	4.07 1.96	8.45	9.06% 0.03	1.06 0.38	2.99
WSW or MSM ^b	21.59% 0.10	1.67 0.72	3.86	8.64% 0.06	1.86 0.25	13.94

^aData from the California Health Interview Survey (CHIS) 2007 sample.

^bWSW = women who have sex with women; MSM = men who have sex with men.

Adjusted Odds Ratios (AOR) are adjusted for race/ethnicity, educational attainment, age, experiences of binge drinking, employment status, and psychological distress (ever and in the past year for intimate partner violence since age 18 and in the past year, respectively).

Lifetime and 1-Year IPV in Men

Table 2 also presents these results for men. In the adjusted model, all three groups of sexual minority men had higher prevalence of lifetime and 1-year IPV, but this was statistically significant only for gay men. Compared with heterosexual men, gay men had about 2.5 odds of both lifetime and 1-year IPV.

Like our findings regarding women, although binge drinking and psychological distress were related to history of IPV, they did not explain the sexual minority disparity in IPV rates. For example, daily or weekly binge drinking in the past year, increased the odds of 1-year IPV (*OR*: 4.03; 95% CI: [2.15-7.55]) and low psychological distress in the past year decreased the odds of 1-year IPV (*OR*: 0.25; 95% CI: [0.16-0.40]) but in testing mediation, the odds

ratios for sexual orientation groups did not differ much in the models with and without these risk factors (not shown).

There were few demographic differences in exposure to IPV. Regardless of sexual orientation, compared with White men, Latinos were less likely and Black men were more likely to experience 1-year IPV (*OR*: 0.42; 95% *CI*: [0.26-0.66], *OR*: 1.99; 95% *CI*: [1.03-3.84], respectively. Race and ethnicity did not have a significant effect on lifetime history of IPV.

Perpetrators of IPV

Although bisexual women had higher levels of IPV than lesbians, WSW, and heterosexual women, the perpetrator was a male intimate partner in 95% of the most recent 1-year IPV incidents that victimized bisexual women. Among the gay men, who had the highest incidents of IPV among the men, the perpetrator was a male intimate partner in 97% of the most recent 1-year IPV incidents.

Discussion

Lifetime and 1-year IPV prevalence were higher in sexual minorities compared with heterosexuals but this was significant only for bisexual women and gay men. We tested whether the higher prevalence of IPV in gay men and bisexual women was explained by two mental health indicators—psychological distress and binge drinking—but this hypothesis was not supported.

Our findings differ from earlier studies that have found that rates of IPV are similar for individuals in same-sex relationships and different-sex relationships (Alexander, 2002; Blosnich & Bossarte, 2009; Burke, Jordan, & Owen, 2002; McClennen, 2005). Possible explanation for this difference may relate to that our approach was different than others in that we relied on a probability sample representative of California population whereas other studies relied on nonprobability samples. Nonprobability samples are more likely than probability samples to incorporate sampling bias. Another distinction is that in our study we categorized individuals by their sexual identity as well as their behavior. Blosnich and Bossarte (2009) who used a probability sample but did not find significant disparities in IPV by sexual orientation, defined sexual minorities as instances where the gender of perpetrator and victim were the same. As we show here, at least regarding women, this approach would obscure IPV disparities because the perpetrators of IPV in bisexual women were men. The finding that IPV in sexual minority women (i.e., bisexuals) occurred most often in the context of a *heterosexual* relationship is consistent with earlier findings (Tjaden & Thoennes, 2000).

It is also possible that limitations in our study explain inconsistencies. Our study has several limitations; most significant is that the CHIS is a representative sample of California's population, which may not be generalizable to the broader sexual minority population. Also, in testing the potential effect of mediators, we assessed the role of two mental health indicators—psychological distress and binge drinking—but these failed to explain the observed sexual orientation disparities in IPV. It is possible better measured mental health mediators could explain IPV disparity in some sexual minority groups. Clearly, the inconsistent findings in the field show that more research needs to be conducted using population samples to assess our finding and explore causes of sexual orientation disparities in IPV.

This article provides insight into the experiences of sexual minorities with IPV that are important to help the antiviolence community, medical health professionals, and public health advocates better understand the unique needs of LGB people and to examine the ways in which current anti-IPV efforts may or may not reflect the realities of IPV in sexual minority communities.

Our finding that gay men's IPV occurred in same-sex relationships but bisexual women's IPV occurred in different-sex relationships suggest that different explanations—and different interventions—should be sought for sexual orientation disparity in IPV in sexual minority men versus women. These findings also support existing efforts to expand IPV screening and intervention efforts to include sexual minorities, particularly gay men and bisexual women (Ard & Makadon, 2011). For example, questions about IPV should be asked of both men and women, regardless of sexual orientation or the sex of a current intimate partner. For bisexual women in a same-sex relationship, a previous different-sex partner may still be involved in incidents of IPV, so screening and intervention should be inclusive of such situations.

Acknowledgments

The authors thank Brad Sears and Susan D. Cochran for reviewing previous drafts, Angeliki Kastanis for assistance with the literature review, and Kathleen Abanilla, Melanie Levy, Christopher Pankonin, and Hongjian Yu from the UCLA Center for Health Policy Research for assistance in conducting analysis using the California Health Interview Survey.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

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Bios

Naomi G. Goldberg, MPP, is a quantitative researcher whose interests focus on sexual orientation and family-related public policy. She graduated magna cum laude from Mount Holyoke College and obtained her MPP from the University of Michigan. Naomi has contributed to a number of projects including the Movement Advancement Project and National Longitudinal Lesbian Family Study.

Ilan H. Meyer, PhD, is Senior Scholar for Public Policy at the Williams Institute for Sexual Orientation Law and Public Policy at UCLA's School of Law. Dr. Meyer studies public health issues related to minority health. His areas of research include stress and illness in minority populations, in particular, the relationship of minority status, minority identity, prejudice and discrimination and mental health outcomes in sexual minorities and the intersection of minority stressors related to sexual orientation, race/ethnicity and gender.