EXPERIENCES OF SCOTTISH MEN WHO HAVE BEEN SUBJECT TO INTIMATE PARTNER VIOLENCE IN SAME-SEX RELATIONSHIPS

RESEARCH REPORT SUMMARY 2022

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Funders

NHS Lothian and NHS Greater Glasgow & Clyde

GCU Glasgow Caledonian University

NHS Greater Glasgow and Clyde

WAVERLEY care Positive about HIV, Hep C & Sexual Health in Scotland

NHS Lothian

The University of Edinburgh

TABLE OF CONTENTS

This report can be cited appropriately in other works as per copyright requirements. The recommended citation is: Maxwell, S. Stenhouse, R. O'Brien, Rosaleen. (2022) Experience of Scottish men who have been subject to intimate partner violence in same-sex relationship: Research Report. Edinburgh: University of Edinburgh.

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1. INTRODUCTION AND METHODS

1.1 INTRODUCTION

The World Health Organisation (WHO) (2021) defines intimate partner violence (IPV) as behaviour by an intimate partner or ex-partner that causes physical, sexual, social, and mental health harm, including violence, sexual coercion, psychological abuse and controlling behaviours. IPV may be more prevalent in male same-sex relationships than in heterosexual relationships (Rollè et al, 2018), with prevalence studies estimating that 34-45% of men in same-sex relationships ever experience IPV (Bacchus et al, 2017; Duncan et al, 2018; Miltz et al, 2019; Stults et al, 2015). Men who experience IPV from same-sex partners have increased risks of mental ill health, substance misuse and transmission of sexually transmitted infections (Bacchus et al, 2017; Miltz et al, 2019; Stults et al, 2015; Duncan et al, 2018; Stults et al, 2019). Identifying and providing accessible support to men who experience abuse from same intimate partners is therefore important in minimising biopsychosocial harm. Some evidence indicates social discourses of masculinity and gay stereotypes prevents men from acknowledging the abuse they experience from partners, or from accessing services (Ristock and Timbang, 2005; Baker et al, 2013). Where men access services, their experience are often not recognised as IPV (Rohrbaugh, 2006) and some experience discrimination (Rollè et al, 2018). There is some evidence that examines IPV among gay and bisexual men (GBM), but these studies are predominantly undertaken from a heteronormative perspective. Such positionality limits the possibility of the evidence base understanding same-sex IPV from the perspective of the person's lived experiences, silencing these voices within the policy and practice context. This limits the effectiveness of policy and practice to provide fully adapted, effective and inclusive support for this high-risk population. This study will address this substantive evidence gap through providing a socio-culturally situated exploration of the lived experiences of men who are subject to same-sex IPV within Scotland. The aim was to understand how men who self-identify as having been subject to IPV within a same-sex relationship dynamic conceptualise and understand their experiences. The objectives were:

1. To identify the relationship factors that influences men's experiences of being subject to IPV within a same-sex dynamic.
2. To identify and describe the types and forms of IPV that men have been subject to within consensually influenced same-sex relationships.
3. To identify and describe the biopsychosocial impact of IPV on men who have been subject to within a same-sex relationship.
4. To identify the perceptions and experiences that influenced men's disclosure and engagement with health, social care and law enforcement services following their same-sex IPV subjection.

1.2 METHODS

Study design

A qualitative narrative approach enabled us to explore participants' experiences through the stories they told in loosely structured interviews. Narrative is the most common way in which people represent their experiences to themselves and to others (Reissman 1993; Gee 1985). Eliciting narratives is supported using loosely structured interviews where the participant is invited to tell their story in relation to the phenomenon being investigated and the interview uses probing questions to invite deeper exploration of the participant's story (Greenhalgh, Russell and Swingelhurst 2005). In this way, the stories that are told are led by the participant rather than the interviewer. Enabling the participant to take the lead in this form of interview supports ethical engagement as the they can manage the topics covered. Where a follow up question asks them to go deeper into something that they would prefer not to, they are more able to say no than in more structured interviews. This study was on a sensitive topic and the design is underpinned by relational ethics and need to ensure ethical engagement through the whole processes.

Participants

10 GBM were recruited via a digital poster on multiple Scottish based GBM charities social media and three advert on a GBM geo-social networking website/apps (Recon, Scruff and Grindr). Men contacted the research team via an email address on the digital poster. Participants were eligible if: 1. Were 18 years old and over, 2. Residing in the Scotland, 3. Self-identified as previously having experienced abuse from an intimate male partner, 4. Believed they would not be at any risk of harm from the perpetrator by taking part in the study, and 5. Felt safe and secure in their wellbeing to discuss their IPV experiences.

Data collection

Between June-July 2022 we conducted single virtual in-depth narrative interviews with 10 GBM. Loosely structured narrative interviews were used to elicit stories from participants who perceived they have been subject to same-sex IPV. Narrative interviews enabled participants to tell their story in their own language, starting where they wanted, and structuring it in a way that made sense to them (Stenhouse, 2013). The interviews began with a broad statement inviting the participant to tell their story in a way that felt comfortable for them. This meant that participants had control of the agenda and presented issues that were relevant to them. As the participants had control of the agenda, the loosely structured interviews enabled them to maintain boundaries around areas that they do not wish to talk about, thus safeguarding against over disclosure (Stenhouse, 2013). This approach more effectively protected participants wellbeing by enabling them to close lines of discussion that they found uncomfortable. SM conducted all the interviewed all the participants via Zoom or telephone. To promote confidentiality, participants were advised to be

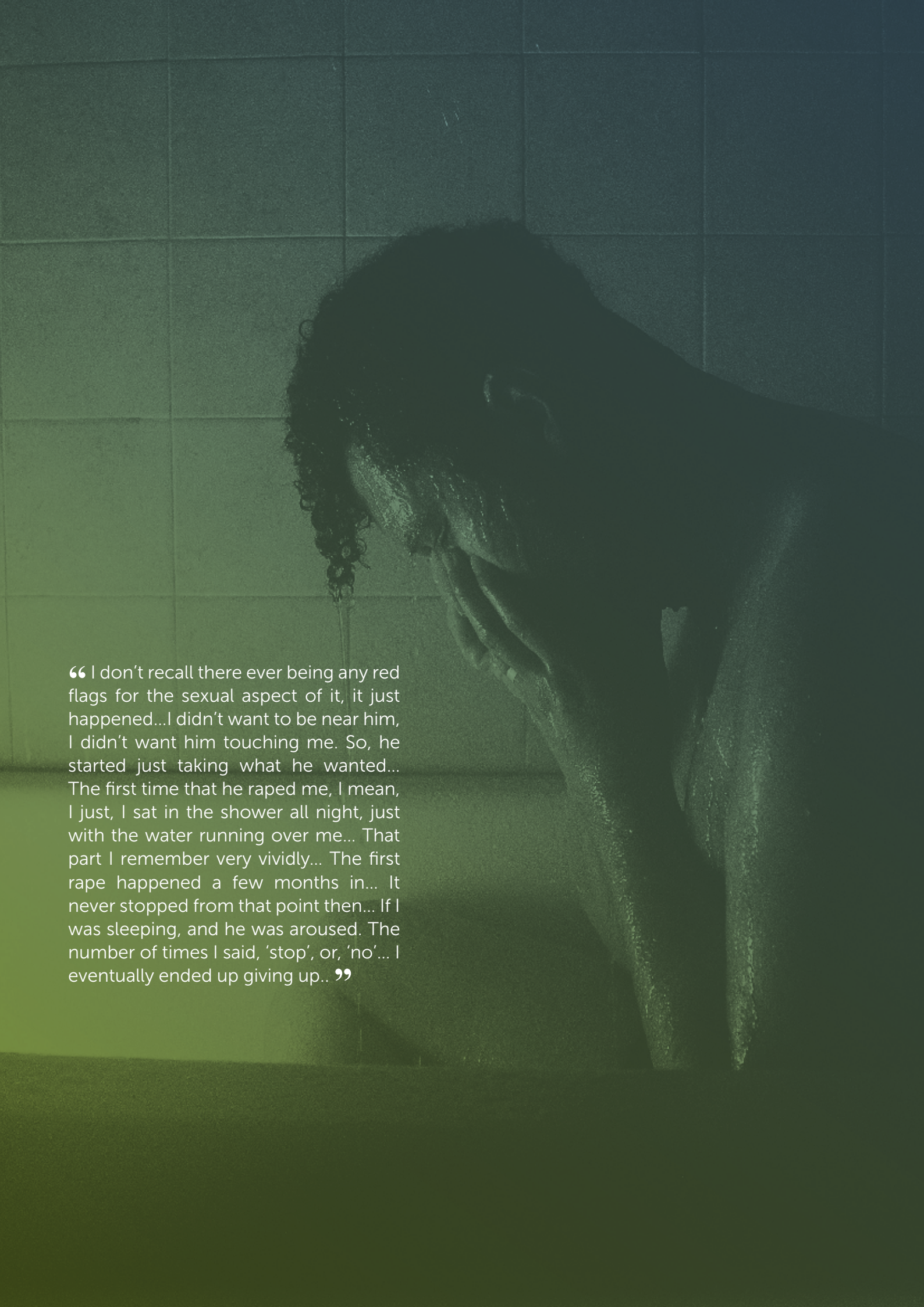
alone in a private enclosed space. Topics discussed during interview were unique relationship factors, types of abuse, impact on wellbeing and barriers/facilitators for attending services. Average interview time was 75 minutes. All interviews were audio recorded and transcribed verbatim by a professional transcription company (1st Class Secretarial).

Data analysis

RO completed all the primary data coding and developed a thematic analysis. The approach was taken to identify themes looking at the data 'vertically' (the whole of each interview) and 'horizontally' (across sub-groups of participants and the overall data). There were five stages in developing the analysis which included 1) Familiarization with data 2) Development of a coding framework based on a combination of a priori ideas and themes grounded in the data; 3) Coding of all data; 4) Thematic mapping, to identify patterns, commonalities, contradictions, and silences within the data set as a whole; and 5) Writing, development, and refinement of an interpretative narrative account. The coding framework was reviewed by all authors at the early stages of data analysis. At the final stage RS and SM independently reviewed the representation of the findings. MAXQDA 22 was used for data management.

Ethics

The study gained ethical approval from Glasgow Caledonian University. The research was designed in a way to support ethical engagement with participants at each stage through involvement of workers from S-X on the advisory committee, consultation through S-X with a person with experience of GBM IPV when considering the research design. The use of loosely structured narrative interviews was intended to level the power imbalance between researcher and participant and was an important aspect in supporting participants to maintain boundaries in the telling of their narratives. Participation was voluntary and informed consent was recorded at the beginning of each interview. Participants were able to withdraw at any time or close any line of enquiry in the interviews. To maintain the anonymity and confidentiality of participants, each has been assigned a pseudonym and features of their stories which might render them easily identifiable, including reference to places and people, have been removed.



“I don’t recall there ever being any red flags for the sexual aspect of it, it just happened…I didn’t want to be near him, I didn’t want him touching me. So, he started just taking what he wanted… The first time that he raped me, I mean, I just, I sat in the shower all night, just with the water running over me… That part I remember very vividly… The first rape happened a few months in… It never stopped from that point then… If I was sleeping, and he was aroused. The number of times I said, ‘stop’, or, ‘no’… I eventually ended up giving up.. ”

2. SUMMARY OF MAIN FINDINGS

The 10 participants were GBM aged over 18 living in Scotland who had previously experienced IPV from an intimate male partner and felt safe to discuss their experiences. Participants had a median age of 32 ranging from 26-47 years (IQR 27-42).

Forms of male same-sex intimate partner violence

1. Most participants described being subjected to multiple forms of intimate partner violence (IPV), including coercive control and verbal, physical, sexual, and financial abuse. 'Gaslighting' was a very commonly used term in the type of abuse all the men had experienced.
2. Some forms of IPV were perceived to be easier to identify than others. However, early warning signs ("red flags"), patterns of behaviour, and escalation, only appeared obvious to most men in hindsight.
3. Much of what many participants described appears consistent with many women's experiences of IPV in heterosexual relationships. However, some experiences relayed unique relationship factors for male victims of IPV in same-sex relationships.
4. Male-on-male IPV assault was perceived societally to be a 'normal' way for men to enact masculinity. Meaning that physical abuse that occurred in public was sometimes ignored and some reports to the police were trivialized.
5. Some participants with big muscular bodies worried that appearing 'acceptably' masculine might make others doubt that they were victims of IPV. Several minimized the seriousness of physical assaults to perform the key practice of 'masculinity'; that of appearing strong and avoiding outward signs of physical weakness.
6. The absence of a rape narrative for men in same-sex relationships made it difficult for most participants to recognise when they had been sexually assaulted. There is a need for awareness raising about what rape looks like when dating other men, in both causal/longer-term relationships, and in same-sex marriage.

> "There is a similar common theme through all types of IPV. It's the possession, the controlling, the feeling of being a dominant person, the feeling of being able to control somebody - is what was present throughout. When your partner becomes controlling, possessive and at times physical, whether that was through just intentional physical harm, but also violence through the relationship, through sex, through intimacy, and just through everyday communications."

7. Those men who recognised they had been raped had been helped by agencies, such as Police Scotland and Rape Crisis, which was to process and define precisely what had happened to them.
9. All participants who were subject to financial abuse were the main providers in their relationships. Some worried that it might be assumed, incorrectly, that this meant they had greater power in their relationships. These concerns were linked to a heteronormative construction of the male breadwinner/ stay-at-home female partner dynamic.

The impact of IPV on wellbeing

1. IPV impacted the mental health of most participants both during, and after the relationships had ended. During relationships, anxiety/panic disorders, eating disorders, self-harm, and a worsening of pre-existing conditions such as obsessive-compulsive disorder were experienced.
2. After relationships ended many participants reported experiencing short-term impacts on mental health, including constant thought rumination and sleep disturbances. Some men out of the relationships for a few years reported longer-term impacts such as PTSD, depression, and suicidal thinking.

> “One-minute things were nice and then horrible, then nice, then it was horrible. It really wore me down physically. It wore me down mentally. I was seeing the doctor a lot more and more. I was gaining weight, comfort eating, and self-harming.”

3. Police involvement which required them to recount what had happened and having court cases ‘hanging over them’ appeared to exacerbate stress, which had both mental and physical health impacts.
4. Participants who had been physically injured by their partners had to engage in a lot of recovery work, which continued to impact their lives long after relationships ended. Some men’s masculine identity was negatively impacted due to scarring and other bodily changes. These were triggering emotionally and transported them back to the traumatic incident.
5. Men who had previously perceived themselves ‘careful’ with their sexual health reported that they began to engage in sexual risk-taking after the abusive relationships ended. Some participants explained this behaviour as possible acts of self-harm, which reproduced the lack of regard their partners showed for their health and safety.
6. Several participants said that experiencing IPV had had an impact on them forming other intimate same-sex relationships. Some men coped by entirely avoiding intimacy entirely, whilst others only formed relationships with clear boundaries.

> “I didn’t want to have sex. I didn’t want to be touched. I didn’t want anybody near me. But at the same time, I wanted to be normal, I wanted all of that. So, it was a very confusing time. Only through doing work with my therapist have I been able to get to a point where I can have a normal relationship, but it’s taken years.”

7. Most participants reported having to wait a long time for NHS mental health support and being offered little emotional support by the police or agencies they were referred to. Few participants had been offered or sought out support to help come to terms with rape and sexual trauma.

Relationship factors within IPV experiences

1. Most participants said they found it difficult to identify what was and was not 'normal' behaviour in a same-sex relationship.
2. Several participants said they lacked friendships with other gay men and LGBTQ role models to guided them on what health same-sex relationships look like. This meant they lacked opportunities to compare notes with peers about how to successfully navigate their first and subsequent relationships.
3. Loneliness appeared to be a common experience for most participants who described difficulties negotiating life as gay or bisexual man in a heteronormative and often homophobic societal context.

> "Like you'll put up with a lot more for a lot less in return. I don't know whether that's to do with you worth. The threshold for straight people that they'll put up with is a lot higher than what you'll put up with in the homosexual. Like if a guy doesn't text a girl back my friends will just block the number whereas because it's so difficult to find someone as a homosexual. I was just grateful that I had someone. I didn't really care how they treated me...I'm going to put up with this until it no longer becomes palatable."

4. In the context of participants partnership development their experience of loneliness appeared to intensify any new intimate relationship. "Red flags" or warning signs were sometimes ignored early in the relationship to preserve long sought-after intimacy.
5. Some participants thought that early warning signs of IPV abuse and how it may manifest in LGBTQ relationships needed to be taught to the wider community and services.

> "I'd spotted a red flag. I think I spotted it quickly, but I didn't want to listen to it, because I just wanted to be loved, I just wanted to be wanted. I just wanted to be normal. And so, I didn't listen to the red flag. And so, I just let it go on and on."

6. Objectification, dehumanization, and rough treatment of male bodies during sex was viewed by some participants as a common dynamic between men in intimate same-sex relationships. These roles sometimes 'spill over' into everyday interactions between partners who performed 'submissive' and 'dominant' roles.
7. Some participants thought that their own vulnerabilities including pre-existing physical and health problems may have made them more susceptible to abuse. Some perceived abusive partners as being vulnerable which led to them to conclude that they might be more worthy of victim status than them. The latter led to some participants tolerating or excusing IPV.
8. Some participants described that their partner's heavy drinking and/ or drug-taking was a "red flag" or a possible risk factor for IPV. Substance use was presented as having a role in either fuelling or damping down IPV.

Barriers/facilitators for IPV disclosure about implications for services

1. Most participants spoke about a general lack of socio-cultural recognition that 'men' could be victims of IPV which made it difficult for them to recognize and disclose to services what was happening to them.
2. Some participants described that documented and shared 'stories' about same-sex IPV experiences was an important step towards improving recognition and helping more male victims to disclose.
3. Most participants described that the public narratives of IPV was perceived to be only a heteronormative dynamic which rendered the IPV experiences of men in same-sex relationships invisible.
4. For some participants LGBTQ experiences of IPV were felt to be entirely absent from the standard 'script' used by agencies and services, making it difficult for them to disclose what was happening. Examples are provided of positive and negative interactions with the police and health services.

> "The police did not treat or regard it as serious. I think it was a complete lack of training. They didn't know how to treat it because it was man-on-man. The police just do not take it seriously...There's just a complete lack of empathy or understanding from the police about same-sex relationships."

5. Many participants believed that developing training to improve staff awareness of LGBTQ IPV in services and networks that gay and bisexual men (GBM) were most likely to have contact with would be beneficial.
6. Some participants perceived that sexual health services were more LGBTQ friendly and accepting which made them a perfect environment to attach specialised same-sex IPV support hubs.

> "It's on and off, on and off, it's nice to know that they (sexual health services) do ask and it's nice to see that obviously they do ask about it and see whether if you are okay. Are you in danger? Do you need help or support? But it's so irregular. It's not part of the process."

7. Psychotherapy was perceived by some participants to be important to help survivors of IPV recover. They described that IPV had resulted in them becoming disconnected from their feelings as they focused solely on their partner's needs. Unravelling the full extent and impact of IPV took months and in some cases years with a skilled therapist.
8. Most participants who received psychological therapy were paying privately which was related to gaining quicker access to support and/or exercising choice over the therapist they saw. They were more comfortable choosing an LGBTQ therapist who may have better insight into same-sex lived experiences and provided benefits in role modelling health relationships.

3. DISCUSSION

3.1 KEY DISCUSSION POINTS

There were multiple findings of interest, but key discussion areas were:

Identifying IPV

The forms of abuse participants experienced were similar to that in wider evidence. However, this study was partially informed by an understanding that there are low numbers of GBM reporting or seeking help following IPV and that whilst there might be a range of barriers evident 'downstream' it might also be that there was an 'upstream' issue relating to how GBM interpreted what was happening in their relationships in relation to the widely available governmental definitions of IPV (Scottish Government 2018; United Kingdom (UK) Government 2018). All the participants experienced difficulties in naming behaviours that they experienced as uncomfortable, or possibly 'wrong', as IPV. Many of the participants felt unsure of what was 'normal' within a GBM relationship. This left them unsure as to whether the initial controlling or sexual behaviours that they did not feel entirely comfortable with were a normal part of GBM relationships. Messinger (2017) identifies a lack of media portrayals of GBM relationships leading to a lack of cultural understanding of what a healthy relationship looks like. In addition, participants tolerated a range of abusive behaviours they were not comfortable with which was driven by loneliness and isolation when not in a relationship. This driver may be based in minority stress (Meyer, 2003) as being part of a minority community, i.e. LGBT.

Difficulties in identifying IPV may arise from the dominant social discourses which position IPV as primarily an act of abuse perpetrated by men on women (Scottish Government 2018; NHS Health Scotland 2019; Stewart, Macmillan, and Kimber 2020; WHO 2012; Messinger 2017). The WHO identifies that IPV is primarily experienced by women (WHO 2012). Although Stewart et al (2020) highlight that most of the epidemiological data on IPV comes from a WHO study of women's health and domestic violence against women, thus the data is from a perspective that has only recognised women as potential victims of IPV. A similarly very gendered perspective is found in the Scottish policies and strategies around IPV and domestic abuse (Scottish Government 2018; NHS Health Scotland 2019). There are instances of public information on IPV or domestic abuse which avoid identifying the gender of victims or perpetrators (United Nations 2020; UK Government 2018). However, these do not take the positive step of stating that men within same-sex relationships experience IPV. Messinger (2017) identifies a need to raise the profile of IPV within LGBTQ communities and start to provide narratives that will enable GBM to identify their experiences. We suggest that spaces need to be made for the voices of GBM who experience IPV which are heard by policy makers and care professionals so that they start to influence evidenced policy and practice.

Accessing support

The dominant discourses around IPV also impact the knowledge and understanding of organisations or health and social care professionals who can support people who experience IPV. For many participants a fear of judgement by professionals either in relation to their masculinity or their sexuality prevented them from accessing support. Such fears were often based on previous experience where their needs for support were either ignored, or actively dismissed. The interpersonal response of those professionals who made that first contact with GBM who were experiencing IPV was associated with the participant's future actions or intentions around seeking support from professionals. In some cases, it was the system, most often the criminal justice system, which created the most distress.

> "I feel like they're (the police) used to speaking to women all day, all the time, that have been harmed by men. And I feel like when I've come in with my case, I feel I'm potentially this random anomaly that they'd have to deal with. I feel like I'm quite embarrassed to tell them that I was in a relationship with a man, that I was getting beaten up by him, sort of thing."

Health professionals are identified as a key resource in identifying signs of IPV and providing opportunities for people to disclose IPV (NHS Health Scotland 2019). For some participants, interactions with health or social care professionals provided them with a name for what was happening to them, enabling them to recognise the IPV that was occurring. However, where there are opportunities for services to initiate conversations relating to GBM's relationships during routine contact, for example in sexual health services, few participants had experienced this approach to questioning as setting a climate that would facilitate disclosure. The importance of health and social care professionals recognising that IPV occurs within GBM relationships is therefore crucial in providing this support. Wei et al. (2020) affirmed that the foundation of support system for victims of same-sex IPV is family and friends. However, many of the study participants were socially and psychologically isolated from friends and family, limiting the support they might receive. Hence, highlighting a potential need for developing professionals understanding of same-sex IPV and enquiry processes.

> "To be a man and even admit that you were in an IPV relationship, I mean, it knocks your confidence, it knocks your self-esteem, and self-worth... The hatred for yourself. The hatred for allowing it... There's a huge stigma around men coming out as domestic abuse victims, because we're men, we should be able to deal with it, we should be able to fight back."

Impact of IPV

The findings of this study clearly demonstrate the extensive psychological, physical, and relational consequences of experiencing IPV both during and after the relationship. The psychological and emotional consequences had implications for the participants' financial security through impact on employment; on social and family relationships;

and on the ability to consider future intimate relationships. These findings are supported by those of Woodyatt and Stephenson (2016) who identified particularly the lasting impact of emotional violence and its impact on victim identity. Therefore, there are considerable psychological, emotional, physical, and financial costs to the individual and their social support network on both a short- and long-term basis. Arguably this cost is increased where IPV is not identified, and support not accessed. Hence, it is imperative that further work is undertaken to develop resources (cultural, informational, practical) to enable individuals and health and social care professionals to identify IPV in GBM relationships. Additionally, there is a need for acceptable and accessible support for those who experience IPV within GBM relationships.

IPV in GBM relationships is not the same as gender-based violence

The heteronormative context of IPV differs from the context in GBM relationships through the impact of lack of social role differentiations. In this study it is evident that there is no stereotypical gender role associated with men in same-sex intimate relationship when compared with heteronormative relationship where there are clear social roles related to power expectations. According to Goldenberg et al. (2016), the lack of clear-cut roles in same-sex male relationships creates conflict where there is no clear power hierarchy. Dominance in same-sex male relationships can be attributed to psycho-social inequalities creating a power imbalance between partners. Within the relationship, these inequalities can be leveraged as a tool to achieve hegemonic masculinity (e.g., breadwinner role, making decisions, emotional strength) and therefore dominance in the relationship (Finneran and Stephenson, 2014). For instance, studies have reported that the IPV perpetrators had the edge on financial hegemonic dominance (Woodyatt and Stephenson, 2016; Goldenberg et al, 2016).

> “When you look at domestic violence (physical) you always stereotype the victim, you don’t mean to, but you do. You don’t look at a big guy as a victim at all. You just…it’s just the way people are. You always sort of stereotype who’s going to be the victim. Yes, I didn’t fit that victim profile in my mind, and I’m sure in the police’s mind as well… I allowed it, I thought…He was (perpetrator) younger and a lot smaller than me.”

Within this study there is evidence that participants held ideas of the characteristics associated with hegemonic masculinity and dominance – being older, having a muscular body, being more financially secure – which were incongruous with being seen or seeing themselves as a ‘victim’. This incongruity, and particularly the fear of how others would judge them in relation to their masculinity evoking negative stereotypes of GBM, made it difficult for those who were being abused by younger or smaller men, or those less financially secure to seek help.

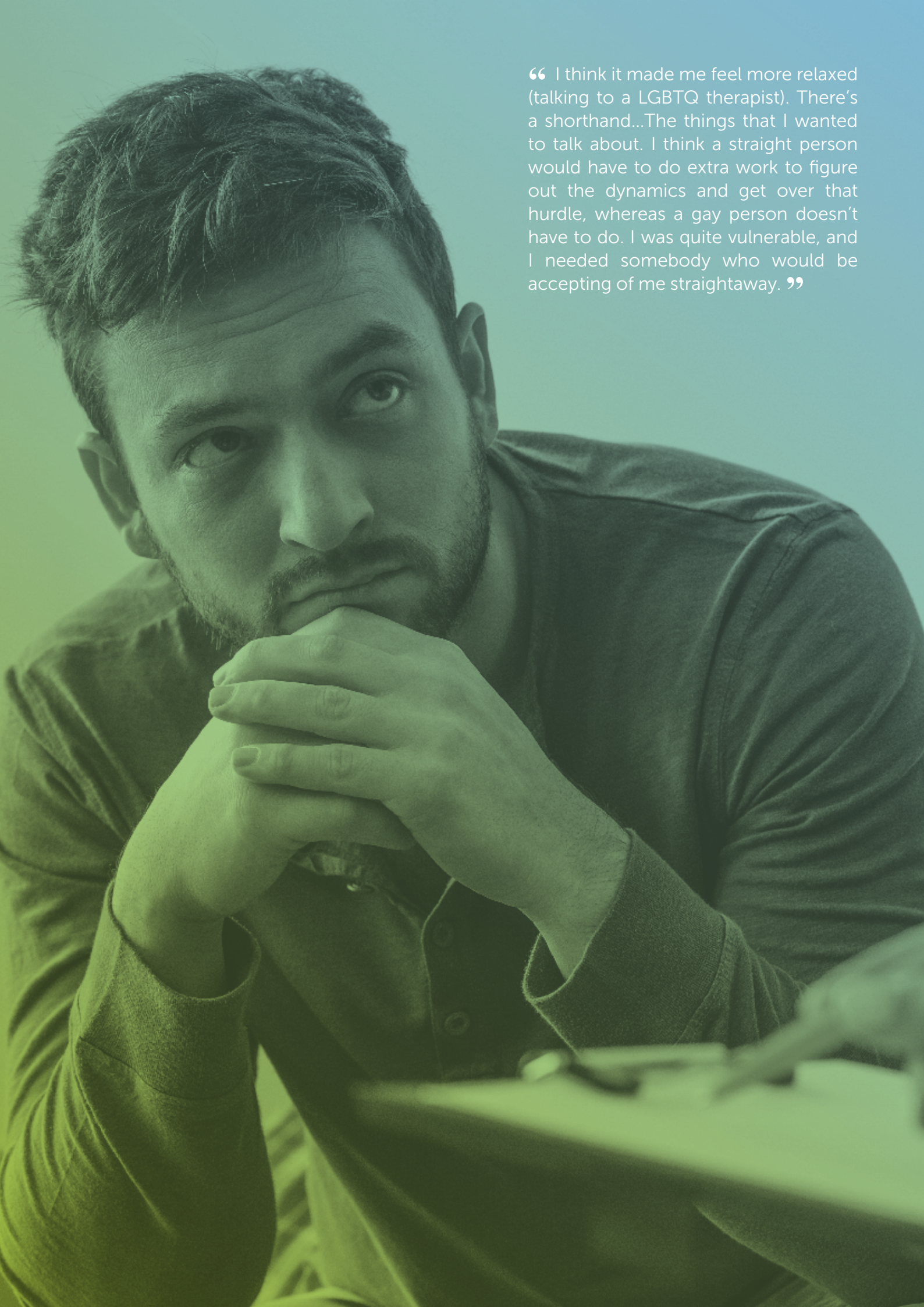
3.2 STRENGTHS AND LIMITATIONS

This is a small narrative study of the experiences of a marginalised group of men. The narrative approach is a study strength, enabling the gathering of rich data focused on a sensitive topic. Such data, enables a deep understanding of the complex and traumatic experiences of participants which can inform policy and practice. This study was designed in collaboration with an advisory group and service users to ensure that the design was responsive to the sensitivity of the topic and that relational ethics was a central aspect of the research.

Recruitment was undertaken using a range of GBM social media for participants from one nation within the UK. These avenues for recruitment and the limit to residence in a single nation mean that there will be groups of GBM whose voices are not represented. However, qualitative research whilst attempting to capture a range of voices does not aim for representativeness. Findings from this study provide a snapshot of the experiences of a range of men that can sensitise practitioners and policy makers to same-sex IPV experiences.

3.3 CONCLUSION

This study set out to better understand GBM's experience of IPV. Through the analysis of the narratives gathered from participants it is evident that whilst IPV might take a similar form to that identified in heterosexual relationships, the situation of GBM within a marginalised LGBTQ discourse impacts their ability to recognise and name their experiences of IPV as well as impacting their help-seeking and experience of services that they access for support. Thus, there is a need to consider GBM's experiences of IPV separately from those of either men or women in a heterosexual relationship. This has implications for policy makers, and for those who design and deliver evidence-based services that support GBM. In addition, there is a role for educators and those providing relationship education to young GBM which enables them to explore healthy same-sex relationships. Further research is required within Scotland and UK to better understand GBM and wider LGBTQ IPV experiences. Additionally, research to understand the knowledge base and attitudes of professionals working with the health, social care, and justice systems towards same-sex IPV would enable the development of more effective and inclusive person-centred interventions.



“ I think it made me feel more relaxed (talking to a LGBTQ therapist). There’s a shorthand…The things that I wanted to talk about. I think a straight person would have to do extra work to figure out the dynamics and get over that hurdle, whereas a gay person doesn’t have to do. I was quite vulnerable, and I needed somebody who would be accepting of me straightaway. ”

3.4. RECOMMENDATIONS

Recommendations will be developed and recorded in the report following the community knowledge exchange event on the 30th September 2022.

4. REFERENCES

1. Bacchus LJ, Buller AM, Ferrari G, Peters TJ, Devries K, Sethi G, White J, Hester M, Feder GS. Occurrence and impact of domestic violence and abuse in gay and bisexual men: a cross sectional survey. Int J STD AIDS. 2017;28(1):16–27.
2. Baker, N.L., Buick, J.D., Kim, S.R. et al. Lessons from Examining Same-Sex Intimate Partner Violence. Sex Roles 69, 182–192 (2013). https://doi.org/10.1007/s11199-012-0218-3
3. Duncan, D. T., Goedel, W. C., Stults, C. B., Brady, W. J., Brooks, F. A., Blakely, J. S., & Hagen, D. (2018). A Study of Intimate Partner Violence, Substance Abuse, and Sexual Risk Behaviors Among Gay, Bisexual, and Other Men Who Have Sex With Men in a Sample of Geosocial-Networking Smartphone Application Users. American journal of men's health, 12(2), 292–301. doi:10.1177/1557988316631964
4. Finneran C, Stephenson R. Antecedents of intimate partner violence among gay and bisexual men. Violence Vict. 2014;29(3):422-35. doi: 10.1891/0886-6708.vv-d-12-00140. PMID: 25069147; PMCID: PMC4354888.
5. Gee JP (1985) The narrativisation of experience in the oral style Journal of Education 167(1): 9-35
6. Goldenberg, T., Stephenson, R., Freeland, R. et al. (2016) 'Struggling to be the alpha': Sources of tension and intimate partner violence in same-sex relationship between men. Culture, Health & Sexuality. [11 August 2022]. Available from: DOI: 1080/13691058.2016.1144791
7. Greenhalgh T, Russell J, Swinglehurst D. Narrative methods in quality improvement research. Qual Saf Health Care. 2005 Dec;14(6):443-9. doi: 10.1136/qshc.2005.014712. PMID: 16326792; PMCID: PMC1744090.
8. Messinger AM (2017) LGBTQ intimate partner violence University of California Press: Ca., USA.
9. Meyer IH (2003) Prejudice, social stress, and mental health in lesbian, gay and bisexual populations: conceptual issues and research evidence Psychological Bulletin 129(5): 674-697 doi: 10.1037/0033-2909.129.5.674
10. Miltz, A. R., Lampe, F. C., Bacchus, L. J., McCormack, S., Dunn, D., White, E., ... Gafos, M. (2019). Intimate partner violence, depression, and sexual behaviour among gay, bisexual, and other men who have sex with men in the PROUD trial. BMC public health, 19(1), 431. doi:10.1186/s12889-019-6757-6
11. NHS Health Scotland (2019) Domestic abuse: what healthcare workers need to know about gender-based violence NHS Health Scotland: Edinburgh.
12. Reissman CK (1993) Narrative Analysis Sage Publications: Ca.
13. Ristock, J., Timbang, N. (2005). Relationship Violence in Lesbian / Gay / Bisexual / Transgender / Queer [LGBTQ] Communities Moving Beyond a Gender-Based Framework.
14. Rohrbaugh, J.B. (2006), DOMESTIC VIOLENCE IN SAME-GENDER RELATIONSHIPS. Family Court Review, 44: 287-299. doi:10.1111/j.1744-1617.2006.00086.

15. Rollè L, Giardina G, Caldarera AM, Gerino E, Brustia P. (2018) When Intimate Partner Violence Meets Same Sex Couples: A Review of Same Sex Intimate Partner Violence. Frontiers in Psychology. 21;9:1506. doi: 10.3389/fpsyg.2018.01506. Erratum in: Front Psychol. 2019 Jul 19;10:1706. PMID: 30186202; PMCID: PMC6113571.
16. Scottish Government (2018) Equally safe: Scotland's strategy for eradicating violence against women and girls Scottish Government: Edinburgh.
17. Stenhouse R (2013) Unfulfilled expectations: individuals' experiences of being a patient on an acute psychiatric inpatient ward Lambert Academic Publishing: Saarbrucken, Germany.
18. Stewart DE, MacMillan H, Kimber M (2020) Recognising and responding to intimate partner violence: an update The Canadian Journal of Psychiatry https://doi.org/10.1177/0706743720939676
19. Stults, C. Javdani, S. Kapadia, F. Halkitis, P. (2015) Intimate partner violence and substance use risk among young men who have sex with men: The P18 cohort study. Drug and Alcohol Dependence, Sep (154). 54-62.
20. Stults, C. Javdani, S. Kapadia, F. Halkitis, P. (2019) Determinants of Intimate Partner Violence Among Young Men Who Have Sex With Men: The P18 Cohort Study. Journal of Interpersonal Violence, Feb (28). doi: 10.1177/0886260519831374
21. United Kingdom (UK) Government (2018) Domestic abuse in England and Wales: year ending March 2018. London: UK Government.
22. United Nations (2020) What is domestic abuse? Available at: https://www.un.org/en/coronavirus/what-is-domestic-abuse
23. Walker, L. (1979). The battered woman. New York, NY: Harper & Row.
24. Wang, N., Huang, B., Ruan, Y. et al. (2020) Association between stigma towards HIV and GBM and intimate partner violence among newly HIV-diagnosed Chises men who have sex with men. BMC Public Health.
25. Wei, D., Cao, W., Hou, F. et al. (2020) Multilevel factors associated with perpetration of five types of intimate partner violence among men who have sex with men in China: an ecological model-informed study. AIDS Care. [11 August 2022]. Available from DOI: 10.1080/09540121.2020.1734523
26. Woodyatt, C. Stephenson, R. (2016) Emotional intimate partner violence experienced by men in same-sex relationships. Culture, Health, and Sexuality. 18(10). 1137-49.
27. World Health Organisation (2012) Understanding and addressing violence against women: Intimate partner violence World Health Organisation: Geneva. Available at: /https://apps.who.int/iris/bitstream/handle/10665/77432/WHO_RHR_12.36_eng.pdf
28. World Health Organisation (2021) Violence against women Available at: https://www.who.int/news-room/fact-sheets/detail/violence-against-women.

September 2022