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BEYOND THE PROTOTYPICAL:
DEVELOPING A BEHAVIORAL SCREENING TOOL OF
SAME-GENDER MALE
INTIMATE PARTNER VIOLENCE

A Dissertation
Presented in
Partial Fulfillment of the
Requirements for the Degree of
Doctor of Philosophy

BY

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August, 2011

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VITA

The author was born in Anaheim, California, on September 21, 1979. He graduated from Channel Islands High School in 1997. He received a Bachelor of Arts in Psychology from San Francisco State University in 2004, and a Master of Arts in Clinical Psychology from DePaul University in 2007.

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CHAPTER I

INTRODUCTION

Intimate partner violence, commonly known as *domestic violence*, is an insidious public health concern that is estimated to be among the largest social issues affecting couples and families across the United States (US) (CDC, 2006; Island & Letellier, 1991). By definition, intimate partner violence consists of a “pattern of violent and coercive behaviors whereby one attempts to control the thoughts, beliefs, or behaviors of an intimate partner” (Peterman & Dixon, 2003, p. 41). Chapter one of this dissertation provides detail regarding the state of the literature pertaining to intimate partner violence in the US. This chapter begins with an essential introduction to the terminology used throughout this dissertation.

First, the term *same-gender* is used when referring to intimate partnerships that consist of two individuals who identify as the same gender. The term “same-sex” is often used interchangeably with “same-gender.” However, due to its emphasis on biological sex as a moniker for gender identity, the use of the term “same-sex” was not employed throughout this document as the term may not apply to relationships in which one (or both) partners may be transgender or gender-variant.

When referring to the occurrence of violence among same- or opposite-gender couples, *intimate partner violence* (IPV) was employed instead of the commonly used term “domestic violence.” Consistent with the literature, the adoption of IPV stems from the broader utility of the term in referring to intimate, coupled relationships that may not involve marriage or co-habitation (McClennen,

2005). Therefore, it is argued to be a term that is more inclusive of same-gender couples, many of whom do not co-habitate nor have the legal right to marry in 45 states of the Union.

The terms *abuse* and *violence* refer to harmful behaviors enacted from one individual unto another and will, therefore, be used interchangeably. Also throughout this dissertation the terms *victim*, *perpetrator*, and *abuser* will not be employed when referring to individuals who have been in relationships involving IPV. For several notable reasons scholars have begun advocating against the use of terms like *victim*, *perpetrator* and *abuser* (McClennan, 2005; Ristock, 2002). This shift in terminology is due, in part, to the traditional socially constructed notion of IPV victim hood, which situates the characterization of a victim diametrically opposed to that of a perpetrator/abuser. Within this dichotomous paradigm a victim is viewed as disempowered, innocent, lacking in agency, weak, non-retaliatory, and typically as a heterosexual female; whereas a perpetrator/abuser is overpowering, controlling, strong, calculating, and most often a heterosexual male (Lamb, 1999).

Parker (1990) first argued against the use of “victim” when referring to individuals who have experienced partner abuse because the term dichotomizes individuals into “impossibly discrete” (p. 177) categories of victim versus perpetrator. According to Parker (1990) these categories do little to recognize the likelihood that those considered “perpetrators” are often victims of earlier forms of abuse, including violence from previous intimate partners. For an overwhelming number of opposite-gender couples this traditional characterization

of IPV victim hood may be accurate (Tjaden & Thoennes, 2000); however, it is an arguably less reflective characterization of same-gender couples where IPV is present.

Ristock (2003) also highlighted the problematic nature of the term “victim” in the context of a same-gender IPV relationship in her work with lesbians involved in IPV relationships. Specifically, a high proportion of her sample reported one-time instances of violent retaliation against abusive partners out of self-defense. These women, whose violent behaviors occurred in the context of retaliation or self-defense, were less likely to believe that the label of “victim” applied to them, and more often (albeit reluctantly) considered themselves “abusers” on account of their singular acts of partner maltreatment. Their difficulty in categorizing themselves within the prescribed victim-perpetrator binary resulted in their failure to gain access to supportive services regarding their experiences of partner abuse. For gay/bisexual men in IPV relationships, a clear distinction between victim and perpetrator may be equally confusing as they, too, contend with traditional notions of what constitutes a victim or perpetrator of IPV (Merrill & Wolfe, 2000). Consistent with Ristock’s (2002) suggestion, and wherever possible (i.e., when not employing terms or labels cited from previous studies), labels such as victim, survivor, perpetrator or abuser will be replaced with phrases like “individuals who have experienced violence” or “individuals who use abusive behaviors.”

The remainder of this chapter will continue defining IPV in the context of same-gender male relationships. First, this chapter will outline forms of intimate

partner abuse—some that are believed to be universal to opposite and same-gender couples (Pence & Paymar, 1993). Included in this discussion are acts of violence to which same-gender male couples are believed to be especially susceptible (AVP, 2003; Roe & Jagodinsky, n.d.). Moreover, the chapter will outline epidemiological data concerning the rates at which same-gender male IPV occurs, and how the theoretical underpinnings of IPV impact the accurate collection of these epidemiological data. The chapter will also discuss behavioral assessments and screeners of IPV, and the appropriateness of such techniques for determining the presence of IPV in same-gender male couples. The chapter will conclude with a rationale and set of research questions guiding the dissertation study.

Forms of Intimate Partner Violence

The forms of abuse that are described in this subsection have been identified by several social service and advocacy organizations at the forefront of the anti-IPV movement. These organizations have developed several circular models, often referred to as “wheels,” to highlight the myriad forms in which violence may materialize in intimate partnerships (AVP; 2003; Pence & Paymar, 1993; Roe & Jagodinsky, n.d.). References to these wheels and their accompanying appendices (Appendices A-C) will be made throughout this portion of the chapter.

The Domestic Abuse Intervention Project (DAIP) of Duluth, Minnesota, proposed the first of these models to aid in the behavioral intervention of heterosexual men who used abuse against female partners (Pence & Paymar,

1993; Appendix A). The “Duluth Model,” as it is commonly referred, is a feminist-based model that attributes all forms of IPV to an inter-partner dynamic where those who use abuse (i.e., males) *always* retain greater power and control in the relationship than compared to their female partners (Pence & Paymar, 1993). The model’s emphasis on the abuse of power and control dynamics is a key element to the declaration of IPV. This definition is also intricately intertwined with theoretical assumptions of feminist-based conceptualizations of IPV (i.e., patriarchy), which will be discussed at length later in this chapter. The use of such wheels in clinical practice persists despite such feminist-based models having been disavowed by several theoreticians as irrelevant to the experiences of same-gender couples experiencing IPV (Blasko, Winek, & Bieschke, 2007; Merrill, 1996; Ristock, 2002).

Given that the Duluth Model was initially developed to address IPV among opposite-gender couples, several other models were later developed to address IPV among same-gender couples. The Texas Council on Family Violence (TCFV) adopted a version of the Duluth Model that was adapted by Roe and Jagodinsky (n.d.) (Appendix B). This model closely resembles the DAIP wheel but also incorporates the systemic influence of heterosexism on all forms of abuse. The TCFV model amends the Duluth model’s category of “Using Male Privilege” to “Using Privilege” so as to more generally apply to same-gender male and female couples. Whereas the original Duluth model was developed to address IPV among men who are “batterers,” the TCFV is adapted for use with “victims” or “survivors” of IPV. The New York City Gay & Lesbian Anti-

Violence Project (AVP, 2003) developed another wheel that was specific to same-gender IPV. Among the highlighted forms of abuse in this model are “entitlement,” forms of gender and sexuality identity discrimination, and HIV-related abuse. The AVP model defines each form of violence abstractly in the third-person tense so that it may apply to both people who use abuse as well as those who experience abuse.

Although forms of IPV will be outlined separately here, by no means does this approach to describing partner abuse denote that forms of IPV occur in a manner that is exclusive or discrete. That is, various forms of violence often co-occur within various contexts of an IPV relationship regardless of the gender of the parties involved (Houston & McKirnan, 2007; Renzetti, 1992; Walker, 1979). Some of these forms of violence are characterized by specific incidents of conflict that are easily identifiable, while others may be more long-standing, psychologically based and, therefore, less easily identified. Assumptions regarding the patterns by which IPV occurs in relationships have influenced the way in which IPV is theoretically conceptualized, and these patterns will be discussed later in this chapter.

Male gender pronouns will be used when referring to individuals who have experienced or used abuse in the context of an intimate partnership. It is important to note that opposite-gender couples comprise the majority of relationships involving IPV (CDC, 2006). However, the use of male gender pronouns throughout this section is intended to assist the reader in considering IPV dynamics in the context of same-gender male relationships.

Psychological and Emotional Abuse

Psychological and emotional forms of abuse include a range of categories as well as specific techniques of abuse (Gay Men's Domestic Violence Project, 2008; Pence & Paymar, 1993; Roe & Jagodinsky, n.d.). Generally, these forms of abuse consist of the use of words, physical or emotional withdrawal to indicate neglect, or the use of other non-physical behaviors to control, intentionally hurt or belittle another person (Pence & Paymar, 1993; GMDVP, 2008). As can be gathered from the various forms of abuse enumerated in the three accompanying power and control wheels (Appendices A-C), psychological forms of violence may include: using coercion, intimidation, social isolation, or entitlement and privilege over a partner.

Other forms of psychological abuse may consist of threats of physical violence intended to cause fear in the partner. For example, one partner may threaten to physically hurt another with an object or weapon, punch walls or doors to imply a physical threat to the partner, or may threaten to physically destroy or hurt the partner's property, loved ones, or pets (AVP, 2003). HIV-related abuse, including threats to reveal a partner's health status as HIV-positive or threats to deny him care, may also fit within the category of psychological abuse.

Stalking is yet another psychological form of violence (Ristock, 2002). In more conventional terms it involves either physically following a partner throughout the partner's day, with or without the partner's knowledge, or having a partner periodically "report in" when he is away. "Tech stalking" is a more recently discussed form of stalking that refers to the use of electronic

communication by individuals who use abuse (e.g., cellular telephone texting or phone calls, messaging via Internet social networking sites, etc.) to dominate, humiliate and harass their partners (National Teen Dating Abuse Hotline, 2008). Of those who use abuse, Renzetti (1992, p. 115) noted that they frequently tailor their abuse “to the specific vulnerabilities of their partners.” Males who have experienced abuse from their same-gender partners may be especially susceptible to tech stalking given the advantage the Internet provides in maintaining a covert connection between two male partners who may wish to keep their relationship discreet to escape psychological heterosexism.

While emotional abuse is considered a form of psychological abuse it is often considered unique in that emotional abuse targets an individual’s sense of self. Thus, techniques of emotionally abusive behavior may include the use of intimate knowledge to generate a partner’s sense of vulnerability, name-calling, blaming, belittling a partner in front of his friends, making a partner feel as though everything is his fault, and instilling a sense that nothing the partner does will ever be “good enough” (Follingstad, Rutledge, Berg, Hause, & Polek, 1990).

Also considered a form of emotional violence is the phenomenon of “crazy-making” or “gaslighting,” which refers to an especially insidious form of violence that is intended to create a sense of confusion in the targeted partner. This form of abuse was made familiar in the 1940’s film, *Gaslight* (Cukor, 1944), where a woman is constantly made to feel as though she is in a state of madness and delirium by her male partner. To the intended audience of heterosexual men who use abuse, The Duluth Model (Pence & Paymar, 1993) refers to this strategy

as “making her think she’s crazy.” In male same-gender cases where this form of abuse is employed, men who use abuse may lie to confuse their partners, blame the partner for instances of violence, manipulate their partner’s words, and minimize their partner’s experiences or statements by refusing to acknowledge the occurrence of actual events, including previous instances of abuse (GMDVP, 2008).

The “bruises” from psychological and emotional abuse are often invisible. More obvious to denote are the effects of physical abuse, which usually arise in the context of a conflict (Dobash & Dobash, 1984; Straus, Gelles, & Steinmetz, 1980). As referenced in Renzetti’s (1992) study, physical abuse often manifests following a pattern of psychological and emotional abuse.

Physical Abuse

Physical abuse refers to “using physical force to control and intimidate a partner...” (Burke & Follingstad, 1999 as cited by Rohrbaugh, 2006). Some commonly identified examples of physical abuse may include hitting, beating, choking, pushing, pulling hair, scratching, throwing objects at the partner, and forcibly preventing the partner from leaving a violent situation (Pence & Paymar, 1993; Roe & Jagodinsky, n.d.). Individuals who use physical abuse may also forcibly restrain a partner’s physical movement, or lock a partner up without his consent (Bannon, 1993).

Those who experience abuse may also be denied food, sleep, or other basic needs (GMDVP, 2008). The act of physically withholding or refusing to help one’s partner, who may require medical care or assistance, would be more

appropriately considered an act of physical violence (AVP, 2003). This form of abuse is especially salient for men who are in same-gender relationships where the role of HIV-related illness may be more present than in heterosexual relationships (Relf, 2001).

The effects of physical abuse can include physical scarring, emotional trauma, or death. Similar to other acts of physical abuse, sexual abuse may leave physical and emotional scars (Campbell, 2002). Sexual abuse can also co-occur with other forms of physical abuse, as well as psychological and emotional abuse (Houston & McKirnan, 2007).

Sexual Abuse

Sexual abuse is both a physical as well as a psychological/emotional form of violence (Merrill & Wolfe, 2000). This form of abuse is any forced or coercive sexual act or behavior that is motivated to establish or maintain power and control over an intimate partner (Burke & Follingstad, 1999; Merrill & Wolfe, 2000). A more widely identifiable form of sexual abuse is rape. However, a man who uses sexual abuse may also force his partner to do sexual acts with him or others, or assault his partner's genitalia (AVP, 2003; Houston & McKirnan, 2007).

More specific to populations especially vulnerable to HIV/AIDS, are forms of sexual violence that threaten one's ability to maintain sexual health. These abusive behaviors may include refusing to comply with a partner's request for safer sex, violating perceived monogamy by having sex with others, and coercing/physically forcing one's partner into having sex with oneself or others (GMDVP, 2008; Heintz & Melendez, 2006). Bondage-Dominance-Sado-

Masochism (BDSM) advocates and allies have also noted that in BDSM play, a partner's refusal to practice, negotiate, or respect pre-established safety parameters or words may be considered sexual abuse (Bannon, 1993). In contrast to physical, emotional and sexual forms of violence, other forms of violence remain generally understudied (Martin, 1976; Merrill & Wolfe, 2000; Walker, 1979). Two such examples are financial/economic abuse and identity abuse.

Economic/Financial Abuse

Economic abuse, also referred to as financial abuse, can operate in two different ways and has been identified among opposite- as well as same-gender male couples (Martin, 1976; Merrill & Wolfe, 2000; Walker, 1979). In one form, economic abuse may consist of preventing a partner from establishing his financial independence. The other form may consist of controlling or manipulating a partner's financial resources for one's own benefit. Individuals who employ economic abuse may practice a number of tactics including forbidding a partner from working, refusing to work while forcing a partner to take care of one's financial needs, taking or keeping money from a partner, increasing debt without a means to pay it off, and forging a partner's signature on financial documents.

In a form of abuse sometimes referred to as "Entitlement" or "Privilege Abuse," a partner who uses abuse may use his economic status to determine roles, responsibilities, or norms in the relationship (AVP, 2003). Most often this may entail a financially stable partner playing a more dominant role in controlling the purchase of clothes, food, or other items. Aside from financial abuse, identity

abuse is another understudied form of violence that may more commonly exist within same-gender relationships where partners may be susceptible to various forms of social discrimination on account of their multiple identities.

Identity Abuse

Identity abuse refers to the strategic use of potentially shaming personal attributes to control a partner (GMDVP, 2008). In other words, this form of abuse is intended to manipulate and control an individual through the implementation of social stigma. Within same-gender intimate relationships, these stigmas are often rooted in forms of socio-political oppression including heterosexism, ableism, age-ism, and racism (Bograd, 2005).

A partner who uses identity abuse may disclose the sexual identity, gender identity or health status (e.g., status as HIV-positive) of a partner to his family, friends or coworkers. Other examples may be asserting that a partner is too old, too sick, or too unattractive to find another partner; justifying or blaming violence on an aspect of a partner's identity; ridiculing the partner's gender expression or identity; or using the partner's own discomfort with his sexuality to incite homophobic fear in him (GMDVP, 2008; McClennen, 2005).

The various forms of abuse that may be present in a relationship involving IPV cross a number of dimensions—physical to non-physical or verbal to non-verbal. The co-occurrence of physical violence with other forms of violence exemplifies the intertwined nature that comprises IPV across various contexts of a relationship. After considering the multiple ways in which violence is aggressed from one partner unto another, one may be left to wonder about the presence of

these forms of violence in the average same-gender intimate relationship. These questions, related to the epidemiology of IPV, will be highlighted before discussing the various theoretical conceptualizations of IPV.

Epidemiology of Same-gender IPV

Researchers who have studied rates of IPV among same-gender couples have likely recognized the importance of these data in gaining societal recognition and legitimization of the issue in the arenas of social and health services. The majority of research on same-gender IPV is relatively small in comparison to IPV research conducted among opposite-gender couples. This body of research has been conducted primarily among lesbian women and has focused on acquiring an accurate estimate of IPV prevalence (Johnson, 2008). Few studies have documented rates of IPV among gay/bisexual men (Ristock, 2003). Most often reviews of this small body of literature cite IPV as equally prevalent in same- and opposite gender couples with rates between 25 and 50% (McClennen, 2005; Peterman & Dixon, 2003; Rohrbaugh, 2006).

When examined closely, however, research on same-gender IPV has been largely unsuccessful at providing consistent rates of IPV among same-gender couples. Survey research conducted over the past 20 years has found that a wide range of lesbian couples—between 17 and 52%—report the occurrence of IPV in their current or past relationships (Brand & Kidd, 1986; Lie & Gentlewarrier, 1991; Loulan, 1987). Some form of partner abuse was reported among an equally wide range of gay/bisexual men – between 11 and 48% – who were sampled by convenience from LGB-specific community events (e.g., LGBT Pride festivals)

(Bryant & Demian, 1994; Houston & McKirnan, 2007; McHenry, Serovich, Mason, & Mosack, 2006).

The National Coalition of Anti-Violence Programs (NCAVP) is a network of programs addressing violence among and against members of LGBT communities. According to the NCAVP, estimates of same-gender IPV prevalence are based on surveillance data gathered from reports filed by law enforcement officers (NCAVP, 2006). According to these national data, the average gay/bisexual male is likely to experience some form of IPV in two out of five romantic relationships—a statistic most comparable to that of heterosexual women (CDC, 2006). However, even these data may be inaccurate given that some individuals involved in same-gender “domestic disputes” may refrain from notifying law enforcement officers of their abuse. Those who do notify law enforcement officers of abuse may go ignored or under-reported by officers who may not recognize instances of same-gender IPV that do not involve physical abuse (Potoczniak, Mouro, Crosbie-Burnett, & Potoczniak, 2003). In addition to limitations in gathering accurate surveillance data, study samples consisting of participants gathered by convenience have resulted in a body of literature that elucidates a largely homogenous population (Johnson, 1995).

A small minority of studies have supported the claim that same-gender IPV, like IPV occurring among opposite-gender couples, is equally present across ethnic/racial communities (Houston & McKirnan, 2007; Toro-Alfonso, 2004). However, the current body of literature has strayed little from studying predominantly European American samples of men involved in same-gender IPV

relationships. In addition to racial/ethnic homogeneity in sampling, no known research exists that documents rates of same-gender IPV among rural versus suburban/urban populations, or among younger versus older groups of gay/bisexual men. One known study (McHenry et al., 2006) conducted among a convenience sample of gay/bisexual men found an association between participants' penchant for violent behavior and education, where the strongest association was between participants of lower education status and physically violent perpetration.

In addition to sampling techniques, the broad ranges of IPV rates across these studies were due to inconsistencies concerning how each study operationally defined IPV. These inconsistencies in defining same-gender IPV are both partly the *source* and partly the *outcome* of unreliable epidemiological data. On the one hand, the definition of what behaviors constitute same-gender IPV play a role in determining what behaviors are measured and presented in behavioral surveillance (Burke & Follingstad, 1999). In turn, the epidemiological data based on these measures sustain beliefs that these behaviors alone constitute IPV, and are worthy of continued surveillance. The narrowed scope within which some scholars view IPV remains despite behavioral health and anti-violence advocates raising awareness regarding the presence of other forms of violence (Potoczniak et al., 2003) and the patterns in which these forms manifest (Johnson, 2008). Based on a literature review of studies pertaining to same-gender IPV, Waldner-Haugrud, Vaden Gratch, and Magruder (1997) found that lower rates of victimization were reported in studies where IPV was defined only in terms of

physical abuse; whereas studies where higher rates of IPV were reported often measured IPV using the Conflict Tactics Scale (Straus, Gelles, & Steinmetz, 1980).

The Conflict Tactics Scale is a self-report behavioral assessment originally designed to measure conflict management in the context of marital relationships. The measure takes into account physical/non-physical conflict tactics, as well as the frequency by which heterosexual respondents were “victims” versus “perpetrators” of such tactics. The Revised Conflicts Tactics Scale (i.e., CTS2) is the most commonly used IPV behavioral assessment, and it is a tool that has been more widely used other among same-gender couples than compared to any other tool (Straus, Hamby, Boney-McCoy, & Sugarman, 1996).

After rewording items within the Conflicts Tactics Scale to apply to non-heterosexual respondents, Waldner-Haugrud and colleagues (1997) surveyed a convenience sample of 283 gay men and lesbians. The rates of IPV among this study sample were generally consistent with ranges of prevalence found among other convenience samples of lesbians and gay men; however, these findings suggested that gay/bisexual men less often experienced *and* used violent tactics than lesbian women. Specifically, 29.7% of gay/bisexual males and 47.5% of lesbian women indicated being the “victim” of relationship violence, while 21.8% gay/bisexual males and 38% of lesbians indicated being a “perpetrator” of violence unto their partners.

At first glance, these trends of abuse experienced by lesbian women suggest that they represent the majority of “victims” and the majority of

“perpetrators” of IPV. In their own research, conducted primarily among heterosexual samples, the authors of the measure have noted that women often report higher levels of abuse than do males (Straus, 1990; Straus et al., 1996). This trend occurs even in cases where these women are clearly the partners who are regularly targeted by abuse. The creators of the measure attributed the apparent phenomenon to socializations of violence between the genders. Specifically, this pattern was explainable by men’s tendency to *underestimate* (and under-report) both their employment of and victimization from severe violence. Women are believed to more accurately depict their experience of abuse from partners, but also have a tendency to *overestimate* (and over-report) their own use of violence. Given the measure’s tendency to misrepresent both the scores of women who use abuse and men who use *and* experience violence the accuracy of epidemiological findings from this study are questionable. In addition, the study’s reliance on a convenience sample, upon which no randomized or probabilistic selection occurred, limits the generalizability of its findings.

Greenwood, Relf, Huang, Pollack, Canchola, and Catania (2002) were interested in documenting what they considered to be a more accurate picture of same-gender IPV victimization among males. Their study sample consisted of a large, probability-based sample of 2,881 men who either reported engaging in same-gender sexual behavior since the age of 14, or who identified as “gay,” “homosexual,” or “bisexual.” The study examined the prevalence of physical, psychological, and sexual victimization among these men. Aside from an interest

in adhering to a “standard definition” (p. 1964) of abuse, the authors’ rationale to select only these three forms of victimization is unclear (Greenwood et al., 2002). Using a modified version of the CTS2, participants were asked to recall whether or not they experienced any of these forms of violence from an intimate partner at least once in the previous five years.

Results indicated that 39% of the entire sample reported experiencing some form of victimization from an intimate partner in the previous five years. Of those who experienced some form of victimization, 22% of respondents were victims of physical abuse, 34% were victims of psychological abuse, and 5% were victims of sexual abuse. Approximately 18% of those who experienced victimization from an intimate partner reported experiencing more than one form of victimization over the previous five years (Greenwood et al., 2002). The findings of this study may more accurately reflect national rates of same-gender male IPV victimization given that it is based on a randomly selected sample (CDC, 2006). However, several misgivings have been expressed regarding the employment of the CTS2, in addition to those concerning its misrepresentation of IPV across genders (Cook & Goodman, 2006; Straus, 1990). For example, it has been noted by some that the use of the CTS2 as a measure of “victimization” or “perpetration” is problematic as this tendency toward categorization may inaccurately capture IPV behavioral surveillance data (Cook & Goodman, 2006; Ristock, 2002; Straus, 1990). A discussion concerning the limitations of the CTS2 as a self-report behavioral assessment will continue later in this chapter.

Responding to a call for more contextualized approaches to understanding same-gender IPV (see Peterman & Dixon, 2003; Ristock, 2002), a more recent Canadian study examined the context in which physically and psychologically abusive behaviors co-occurred within male, same-gender relationships (Stanley, Bartholomew, Taylor, Oram, & Landolt, 2006). Using a semi-structured interview guide the authors conducted face-to-face qualitative interviews among a probabilistic community-based sample of 195 gay and bisexual men.

Sixty-nine participants in this sample (35%) reported that at least one violent episode occurred in the context of a same-gender intimate relationship. To determine the extent to which these 69 participants used or experienced IPV within their relationships, Stanley and colleagues (2006) utilized a qualitative assessment of IPV. Replicating an approach used in other research (Cascardi & Vivian, 1995), participants were asked to share details concerning the most severe violent incident from their most recent violent relationship, as well as characteristics of violence throughout their recent violent relationship. Results from qualitative data analysis indicated that physical violence most often occurred in a bidirectional (or mutual) manner, and in single as well as recurring instances. Specifically, 44% of respondents indicated that both partners used what could be classified as physically abusive behaviors during a most recent violent incident. A larger proportion of respondents (50%) indicated that *both* partners used physically abusive behaviors throughout the extent of their most recently violent relationship (Stanley et al., 2006).

These findings suggest that the binary conceptualization of IPV, with its mutually exclusive classification of “victim” and “perpetrator,” does not reflect the experience of 44-50% of those who report being involved in relationships where both partners use physical violence. This pattern is also confirmed among lesbians, as two-thirds of a national sample of lesbian women who experienced IPV reported being both the victim and perpetrator of IPV in previous relationships (Lie, Schilit, Bush, Montagne, & Reyes, 1991). Most notably, these findings are consistent with other research that highlights the difficulty that service providers often face when assessing IPV in same-gender relationships, where “prototypical” behaviors that are often reflected in IPV epidemiological data may resound less in clinical presentation (Blasko, Winek & Bieschke, 2007). As already highlighted, researchers have noted the added difficulty of assessment approaches that are based on heteronormative models originally developed to assess heterosexual male-female IPV (Cook & Goodman, 2006; Ristock, 2003).

Thus far, the chapter has provided a basic lexicon of terminology concerning same-gender IPV, followed by an outline of forms of IPV. The chapter has also highlighted the inconsistencies of epidemiological surveillance data, which are based on convenience samples that are largely homogenous in terms of race, ethnicity, age, and residential dwelling. Two featured studies were praised for attempts to gain representative samples; however, their employment of the CTS2 influenced the way in which IPV was defined and measured.

The collection of accurate epidemiological data has notable implication for the continued study, treatment, and prevention efforts geared toward same-

gender IPV (Rohrbaugh, 2006). The use of behavioral measures must be more sensitive and culturally tailored to the experiences of men in same-gender IPV relationships. These approaches must be adapted to address IPV among males from various communities and sociodemographic groups. This claim is especially noteworthy if indeed the rates of IPV among same-gender male couples are as high as studies highlighted in this chapter estimate. This chapter will continue with a discussion regarding the notable theoretical conceptualizations of IPV, some of which have salient theoretical implications for same-gender male couples.

IPV Conceptualizations

Beginning in the late 1970's feminists in the women's anti-violence movement began addressing what was most commonly referred to as "wife beating" or "wife battering" among heterosexual couples (Pagelow, 1984). This movement began by calling critical attention to the institutionalized role of patriarchy in perpetuating gender-based violence and inequity among heterosexual couples. Contemporaneously, many social scientists began investigating the underpinnings of what was labeled "domestic violence," with an apparent interest in identifying and classifying its occurrence as the result of power imbalances between intimate partners (Ristock, 2003). Two theoretical frameworks emerged from this era: the family violence and feminist perspectives. These two perspectives were originally developed for application with opposite-gender couples, but the emergence of additional conceptualizations of IPV have attempted to understand dynamics of same-gender IPV (Blasko et al., 2007;

Johnson & Ferraro, 2000; Ristock, 2002, 2003). Most of these conceptualizations, including those that have more recently emerged, were examined in the context of lesbian relationships with a minority focusing on same-gender male couples (Johnson & Ferraro, 2000; Potozniak et al., 2003). Each of these conceptualizations is discussed in this portion of the chapter beginning with family violence theory.

Family Violence Theory

Straus and colleagues' (1980) family violence theory takes a behavioral approach to understanding IPV and postulates that partner violence surfaces as only one interpersonal tactic (of several) used to gain control within family conflicts. The family violence theory was grounded in the assumption that non-egalitarian and imbalanced power dynamics between husband and wife were the basis of IPV. Although based on opposite-gender couples, the theory did not inextricably link perpetration to males and victimization to females. However, research conducted among large random samples of US adults indicated the highest rates of partner abuse occurred in marriages where husbands dominated the household (Coleman & Straus, 1986). The CTS was developed to measure the occurrence of IPV according to this conceptualization, focusing on the assessment of violent acts within specific incidents of conflict (Straus et al., 1996). It is the goal of these measures to determine a "victim" and "perpetrator" according to the occurrence of frequent and severe violence. Aspects of the CTS2 will be discussed in more detail later in this chapter.

Cook and Goodman (2006) also focus on the victim-perpetrator dynamic but argue that Straus and colleagues' (1980) theory and accompanying measure are narrowly focused on defining IPV only in the context of a conflict. Therefore, the theory does not account for violence in situations where violent acts may be more subtle and coercive by nature. According to Cook and Goodman (2007), less conflict-based violence may be used to control or coerce a partner across various contexts (outside of conflicts). These forms of violence may include threats, surveillance, restraint, humiliation or a range of other tactics. In addition, the lack of attention to controlling or coercive partner violence in various contexts limits how family violence theory may assess forms of violence unique to same-gender couples (i.e., identity abuse, or HIV-related abuse). Feminist theorists have tended to not follow the family violence approach.

Feminist Theory

According to the feminist perspectives, the patriarchal society in which we live predetermines men as perpetrators and women as victims. This assumption considers patriarchy a key societal privilege granted exclusively to men, and unattainable by women. Therefore, according to this perspective it is intrinsically impossible for women to abuse or men to be considered "victims" of abuse. It is also according to this conceptualization that treatment services to "perpetrators" and "victims/survivors" of IPV have been based (Ristock, 2002; 2003).

This framework is problematic for several reasons. Most obviously, it is heterosexist in its assumption that couples are comprised solely of opposite-gender partners. This heterosexist assumption is problematic in the context of a

same-gender relationship because it does not account for instances in which women use abuse against their female partners, or instances in which males experience abuse from their male partners (Hamel, 2007). In addition, the “victim/survivor versus perpetrator” dichotomy exists in a feminist understanding of IPV, as it does in other understandings of IPV (Cook and Goodman, 2007; Pagelow, 1984; Straus et al., 1980; Walker, 1979). Despite this, feminist-based approaches continue to be used among service providers working with same-gender couples despite the heterosexist assumption of this conceptualization (Blasko et al, 2007).

Another way in which the feminist conceptualization of IPV is problematic relates to clinical practice. Namely, the feminist model prohibits individuals from engaging in couple’s therapy if IPV has been identified in their relationship (Johnson, 2006). That is, “victims” and “perpetrators” are forbidden from engaging in therapy or counseling services together based on the deterministic, and rather disempowered perspective that those who have experienced abuse will be easily powered over by their partners while engaged in a therapeutic relationship (McHenry et al., 2006). The perspective of a “victim” as helpless against all acts of partner violence is a concept that is likely rooted in Walker’s (1979) concept of the Cycle of Violence.

The cycle of violence.

Much of the advances in how feminist researchers and practitioners defined IPV came from the research of psychologist Lenore Walker (1979). Her early work, consisting of 1500 interviews with heterosexual female “victims” of

IPV, fleshed out two notable mechanisms at play that characterize patterns of interpersonal abuse. Her most notable contribution, the *Cycle of Violence*, refers to the gradual and insidious onset of a tripartite pattern of partner abuse (Appendix D). The three phases of the cycle of violence are commonly placed in the following order: (1) Tension-building phase, (2) Acute (or Violent) incident phase, and (3) Honeymoon (or Reconciliation) phase. However the emergence of this pattern, which can emerge as early as the first 6 months into a relationship, may begin with any one component of the cycle.

Walker's (1979) theory regarding the cycle of violence was later empirically supported (Wilson, Verceles, Brems, Benning, & Renfro, 1992). The cyclical pattern has also been confirmed to exist among gay male and lesbian couples (Island & Letellier, 1991; Renzetti, 1992). The phasic nature of this model draws attention to its cyclical pattern as well as the potential likelihood for the overlapping of its phases, as opposed to a unidirectional development with distinct start- and end-points to each of the model's components (as a stage or step model would imply).

In brief, the tension-building phase consists of increased conflict or tension from one partner unto another. In the acute incident phase one partner uses a specific tactic of abuse against the other partner. Following the incident of abuse, and during the honeymoon phase, the partner who used abuse may become contrite, reconciliatory, and make professions of renewed love as well as promises to change.

The cycle of violence is often considered insidious by nature due to the stealthy, gradual and steady increase by which violence emerges and begins to characterize a relationship. As a result, an individual who experiences IPV may not be aware of the pattern until the other partner threatens his/her life. Walker's (1979; 1983) second notable contribution applied the psychological construct of *learned helplessness* to understanding the susceptibility of an individual to fall prey to a cycle of abuse and violence.

According to Walker's (1983) application of learned helplessness, "battered" women may initially seek help, but as attempts of help-seeking are thwarted and prove unsuccessful, these women eventually stop seeking help and resign to the abuse. Walker (1983) outlined the psychological underpinnings of learned helplessness as well as how they related to phases within the cycle of violence.

Specifically, she noted that, beginning with the honeymoon phase, the cycle of violence is first introduced into a relationship by an individual who uses abuse. This is accomplished through a series of "grooming" behaviors geared toward the individual who is the target of abuse. Acts of grooming often involve professions of love as well as verbal and nonverbal exchanges of devotion and interdependence. In this blissful context, the first incidents of violence are then viewed as exceptions, or outright *denied* by both individuals. As the relationship continues, subsequent entries into the honeymoon phase, which typically follow an incident of violence, prompt a sense of *confusion* on the part of the targeted partner and minimize his/her appraisal of how severely violent the relationship

may be. Walker (1979; 1983) noted that with the gradual increase in severity and frequency of violent acts, the individual who experiences abuse often becomes *desensitized* to the violence in the relationship.

Ristock (2002) highlighted how distilled conceptualizations of the cycle of violence are often used to determine eligibility for programs designed to address the needs of “survivors” of same-gender IPV. Somewhat crudely, funding sources often mandate that these programs’ serve either “victims/survivors” or “perpetrators.” Such funding contingencies exist despite evidence to suggest a less clear-cut pattern of partner abuse existing in same-gender couples (Stanley et al., 2006). Reliance on such limited categories appears to represent a disconnection between emerging conceptualizations of IPV and a feminist ideologue that endorses universal categorization. Thus, feminist-based assumptions of a “victim” and “perpetrator” binary continue to inform how we measure, assess, and ultimately serve individuals experiencing same-gender IPV.

Emerging Conceptualizations of IPV

Blasko, Winek, and Bieschke (2007) note that prior to 1995, the family violence and feminist perspectives dominated the field of IPV research, treatment, and advocacy. While these theories highlighted the important role of power and control in IPV, they did little to draw important distinctions between qualitatively different forms and patterns of abusive behavior in IPV relationships (Johnson, 1995). More recently, and with reference to same-gender couples, some have stated that feminist perspectives alone do little to explain IPV dynamics among male couples (Potozniak et al., 2003). Instead these theories only apply patriarchal

constructs that retain a victim-perpetrator binary, while also prescribing heterosexist roles to those who *experience* abuse (e.g., “wife,” submissive, “woman in relationship”) and those who *use* abuse (e.g., “husband,” dominant, “man in relationship”).

Gender symmetry.

As an alternative conceptualization, research-practitioners like Island and Letellier (1991) and Dutton (1994) have argued that IPV is a gender-neutral phenomenon. This concept, referred to as *gender symmetry*, postulates that IPV is perpetuated equally among men and women regardless of their sexual orientation (Hamel, 2007). Originally the concept of gender symmetry was proposed to support the claim that prevalence of heterosexual male IPV victimization is vastly underreported (and therefore underestimated) as a result of patriarchal understandings of couple violence (Hamel, 2007). In support of this claim Island and Letellier (1991) and Dutton (1994) highlighted the occurrence of same-gender partner abuse as evidence contrary to the feminist tenet that patriarchal domination is the root of IPV. The strongest argument against this tenet, according to these authors, is evidenced by the occurrence of women abusing women, and men being victimized and rendered powerless by other men.

Not all researchers agree that IPV is equally perpetuated by both genders (Johnson, 2008; Ristock, 2002). Feminist scholars, including Ristock (2002), have certainly recognized how traditional feminist notions grounded in patriarchy discount the experiences of women who use abuse and men who experience abuse from their partners. As demonstrated by her research with lesbian women, Ristock

(2002; 2003) underscored how the concept of gender symmetry merely highlighted that women and men could be equally categorized as IPV “victims” and “perpetrators.” However, the concept did little to discern patterns of violence unique to same-gender couples. She also noted that gender symmetry has little to no potential to transform the conceptualization of IPV from heterosexist to gender and sexual identity inclusive. Gender symmetry’s maintenance of the status quo is most evident in its implicit categorization of individuals into discrete typologies (e.g., “victim” or “perpetrator”).

Other feminists (Johnson & Ferraro, 2000; Kelly & Johnson, 2008) falsify the presence of gender symmetry based on the notion that there are two possible manifestations of IPV, one of which is not characterized by gender symmetry. While the family violence and feminist theories highlighted the important role of power and control in IPV, they did little to draw important distinctions between qualitatively different forms and patterns of abusive behavior in IPV relationships (Johnson, 1995).

A typology of intimate partner violence.

Social psychologist Michael Johnson (1995; 2008) studied the opposite-gender IPV literature and broadened its scope by identifying two major typologies of IPV that had been studied in the literature to that point— *situational couple violence* (also referred to as “common couple violence”) and *intimate terrorism* (also referred to as “patriarchal terrorism” and “coercive controlling violence”) (Blasko et al., 2007; Johnson, 2008; Johnson & Ferraro, 2000; Kelly & Johnson, 2008). The fundamental difference between situational couple violence and

intimate terrorism is the motivation behind a partner's use of violence. Situational couple violence is characterized by acts of partner violence not connected to patterns of power and control. In contrast to Hamel (2007), Johnson (2006) has highlighted that it is only in instances of situational couple violence that IPV tends to be more gender symmetric. Last, situational couple violence is believed to be more commonly experienced by couples than is intimate terrorism.

Whereas patterns of power and control play no role in motivating instances of situational couple violence, intimate terrorism is “[patterned] violence motivated by a wish to exert general control over one's partner” (Johnson & Ferraro, 2000; p. 949). It is this form of violence that is more likely to escalate over time, more likely to involve serious injury, and less likely to occur mutually between partners. Statistically speaking, those who have experienced intimate terrorism are also more likely to be women, encountered by therapists/researchers in agency settings, and present with psychosocial issues that may include post-traumatic stress disorder (Kelly & Johnson, 2008).

The emergence of these two distinctions followed Johnson's (1995) assessment of the family violence and feminist IPV research literature. He noted that much of the family violence literature was based on large random samples of opposite-gender couples. The majority of this research was quantitative by nature and did little to distinguish these sub-types of IPV. As a result, family violence literature made general assertions about IPV (e.g., gender symmetry hypothesis) based on data that is likely comprised of more cases of situational couple violence than intimate terrorism (Johnson, 1995; Johnson & Ferraro, 2000; Kelly &

Johnson, 2008). In contrast, feminist literature relied more on data of battered women collected from hospitals, shelters, and law enforcement agencies and was, therefore, characterized by what is considered intimate terrorism (Blasko et al., 2007; Johnson, 1995; 2008). No known research exists examining the applicability of Johnson's (1995) distinctions on same-gender couples, but these two forms of IPV are believed to exist among same-gender couples as they do among opposite-gender couples (Johnson & Ferraro, 2000). Still it is important to examine the extent to which these distinctions characterize partner dynamics between same-gender couples (Ristock, 2002).

The distinction between intimate terrorism and situational couple violence broadens the conceptualization of IPV by suggesting that service providers and researchers are each serving two separate groups of individuals who experience qualitatively different forms of IPV. No known research examines whether clinical presentations of same-gender couples (male or female) resemble intimate terrorism, situational couple violence, or another unique presentation. While Johnson's (1995; 2008) conceptualization developed from research conducted among opposite-gender couples, its differentiation among patterns of IPV has theoretical application for same-gender couples (Johnson & Ferraro, 2000; Rohrbaugh, 2006). However, postmodern feminists remain skeptical of categorical models to explain and discern IPV; arguing that same-gender IPV is an altogether subjective language that has yet to be written (Lamb, 1999; Ristock, 2002).

Postmodern feminism.

Postmodern feminism asserts that gender, sexuality, and other forms of human diversity are socially constructed and located “inescapably within language” (Frug, 1992; p. 126). According to postmodern feminism, the way in which language shapes and confines reality determines the extent to which one is disenfranchised or empowered in society. On the one hand, language is insidious in its ability to infiltrate epistemology and assign “natural” or “inherent” characteristics and properties to certain entities (Foucault, 1972). On the other hand, Butler (1995) argues that within language is the potential for empowerment and the powerful resistance of socio-political oppression. Ristock (2003) has endorsed and applied postmodern feminism to understanding same-gender IPV among lesbian women, stating that this viewpoint underscores the importance of constantly reevaluating the predominant narrative of IPV in order to monitor and resist how this “grand narrative” may “exclude some experiences while naturalizing others” (p. 22). Postmodern feminists have equated the restrictions of essentialism with feminist conceptualizations that sustain patriarchy as the root of IPV (Lamb, 1999; Ristock, 2002). Thus, to completely understand postmodern feminism, one must first understand how it developed from more traditional feminist thought rooted in essentialism.

Essentialist philosophy posits that meaning is ascribed to objects or groups based on a set of specific characteristics, properties, or assumptions that any such entities must possess. The features of this entity are therefore permanent, static and eternal, and are present in every possible reality, context and situation (Butler,

1995; Foucault, 1972). According to essentialist thought, gender, sexuality, race, and other group characteristics are considered fixed traits that do not vary across individuals (de Beauvoir, 1974). An example of an essentialist viewpoint that is adopted by feminists who endorse a patriarchal conceptualization of IPV may be that “individuals who are targets of IPV are *always* women/victims, while those who use abuse are *always* men/perpetrators.” Within such a statement, two sets of characteristics are believed to be synonymous with each other and, therefore, essential determinants of IPV (i.e., women as “victims,” and men as “perpetrators”).

Before the emergence of postmodern thought, and as early as the mid-twentieth century, feminists critiqued essentialism as deterministic (de Beauvoir, 1974). Such critiques concerned essentialism’s inability to account for human diversity, and the role that society and culture play in constructing the human experience on dimensions such as gender, sexuality, and race. Using the example of the female, Simone de Beauvoir (1974; p. 301) famously wrote:

One is not born, but rather becomes, a woman. No biological, psychological, or economic fate determines the figure that the human female presents in society; it is civilization as a whole that produces this creature...which is described as feminine.”

More recently, some have stated that feminist-essentialism does not account for IPV dynamics among gay male couples (Potozniak et al., 2003). Instead this particular stock of feminism, albeit the most dominant, only applies patriarchal constructs that retain a victim-perpetrator binary, while also prescribing heterosexist roles to those who experience (e.g., “victim,” “wife,” submissive, “woman in relationship”) and use abuse (e.g., “perpetrator,” “husband,”

dominant, “man in relationship”). Through such an essentialist lens a situation is created where male-male IPV may be completely ignored or rendered impossible. Moreover, gay/bisexual male victims of IPV may have to be seen as female-like in order to fit within society’s limited understanding of IPV (Ristock, 2002).

In advocating for a postmodern feminist lens through which to examine same-gender IPV, Ristock (2003) requires the field to first question two essentialist assumptions that have implications for how same-gender IPV is assessed. First, researchers and practitioners should question their methods of determining who is *using* and who is being *targeted* by partner violence. This question is important to consider along with the consideration that not all forms of violence enacted or experienced among partners may be considered the abusive use of power and control tactics (Johnson, 2006; Rohrbaugh, 2006). Second, the language used to characterize individuals who are targeted by or use violence should transcend restrictive terms like “victim,” “survivor,” or “perpetrator.” To prevent the restrictive influence of an assessment that is feminist-essentialist by nature, an informed IPV behavioral screener must question how violence manifests in a relationship (e.g., who is most often targeted versus who is using the violence), and carefully determine whether this violence is intended to coerce or control the partner across various contexts or situations (Cook & Goodman, 2006; Ristock, 2002).

This discussion focused on the notable conceptualizations of IPV, two of which—intimate terrorism and postmodern feminism—have especially salient theoretical implications for understanding IPV among same-gender male couples.

As recently noted by Blasko and colleagues (2007; p. 259), the occurrence of a heterosexist “prototypical assessment” is prevented when the conceptualization of IPV is broadened beyond an essentialist-feminist framework that underscores patriarchy as the sole proprietor of IPV. Yet, despite their transformative potential, it appears that the emergent conceptualizations of IPV have had little influence on widely used behavioral screening and assessment tools related to IPV. A discussion of topics related to the behavioral screening of IPV will follow.

Behavioral Screening of IPV

The primary goal of any behavioral screening assessment is to engender precise operational definitions of target behaviors as well as intrapsychic and environmental factors that control and sustain these behaviors over time (O’Brien & Haynes, 1995). Behavioral assessments of IPV inquire about two things (although not often within one measure): who is the “perpetrator” and who is the “victim” (Rahus & Feindler, 2004). Males involved in same-gender IPV (regardless of whether one has used or experienced abuse) are challenged with overcoming various effects of IPV, both intrapsychic and psychosocial. Such challenges may include shame-bound isolation, denial, self-blame, general mistrust of others, and shame based on their perceived inability to fulfill their role expectations as intimate partners (Anderson, 1992; Johnson, 1999). Arguably, these challenges influence the degree to which any given researcher or practitioner may accurately assess a male client or participant’s experience of same-gender IPV. This subsection of the chapter will outline the general trends in behavioral assessment of IPV. It will further discuss the elements and limitations

of assessing IPV through a “prototypical” protocol often universally employed by researchers and practitioners (Blasko et al., 2007). This subsection will conclude with a discussion of what elements researchers suggest should be included within an IPV screening tool intended for men in same-gender relationships involving partner violence (Greene & Bogo, 2002; Kelly & Johnson, 2000; Rohrbaugh, 2006).

Trends in Behavioral Screening of IPV

Over the course of the last 30 years, social scientists have struggled with how to operationally define the behaviors of which IPV is comprised (Fisher & O’Donahue, 2006). This struggle has played out almost exclusively within the parameters of opposite-gender relationships with little attention focused on operationalizing the behaviors that constitute same-gender IPV (Johnson, 1995). In the early stages of the field, IPV was defined and measured based on the degree of injury sustained by a female partner from her male partner (Rounsaville & Weissman, 1978; Stewart & de Blois, 1981). Objectivity was considered a chief property of assessments during this period. However, objectivity often relied on arbitrary benchmarks of (e.g., “mild” to “severe physical battering”) to make distinctions between gradations of severity (Straus et al., 1996). Measuring the degree of injury was believed to place too much attention on overt signs of physical abuse, and did not take into account the less obvious injuries and effects of more covert forms of IPV, including psychological and emotional abuse (Gelles & Straus, 1979). Anti-violence advocates and scientists also criticized this

definition for focusing too much on severity of injury while not considering the frequency by which these incidents occurred (Straus, 1990).

To account for the frequency aspect of abuse, the emergence of concepts like “primary” and “secondary battering,” respectively, referred to the first incident of physical battering versus a series of repeated violent incidences (Pagelow, 1984, p. 498-502). Fisher and O’Donahue (2006) note how distinctions between primary versus secondary battering were common and took into account the frequency of violent incidents, but the threshold of what qualified as “violent” was still unclear. To account for the more subtle forms of violence, including the forms from which no physical signs could be identified (i.e., psychological or verbal abuse), definitions of IPV began to consider the role of imbalanced patterns of relational power and control between partners (Pagelow, 1984; Pence & Paymar, 1993; Walker, 1979). The family violence theory, described earlier in this chapter, emerged in the late 1970s (Straus, 1990). As already highlighted, the Revised Conflict Tactics Scale (CTS2) developed from this literature and has since become the most widely used behavioral assessment of interpersonal conflict-oriented violence (Blasko et al., 2007; Straus et al., 1996).

Conflict tactics scale.

The CTS2 is a 78-item self-report behavioral measure comprised of five subscales that assess the extent to which partners (dating, cohabitating, or marital) engage in physical or psychological acts of violence. The CTS2 also assesses respondents’ “reasoning or negotiation to deal with conflicts” (Straus et al., 1996; p. 283). The measure’s continued employment is due to it being the only

assessment (among roughly 20 IPV-related measures of abuse; CDC, 2006b) that examines both the experiences of “victims” and “perpetrators.” Subscales of the CTS2 consist of measures of psychological aggression, physical assault, sexual coercion, physical injury, and the extent to which positive affect is communicated between partners (i.e., Negotiation Scale).

The CTS2 was normed on a sample of 317 college students, with an average age of 21. Sixty-four percent of the sample consisted of females, and the entire sample identified as heterosexual. Despite the CTS2’s normative sample not reflecting diversity in terms of age or sexual orientation identity, it continues to be used as a method by which same-gender IPV is measured in various samples of adults who are, on average, much older than the normative age group (Greenwood et al., 2002; Houston & McKirnon; 2007; Waldner-Haugrud et al., 1997). More recently, concerns have been raised that the CTS2 is limited in its capacity to capture and engender precise operational definitions of violence that may be unique to male couples (Cook & Goodman, 2006; Ristock, 2003).

Limitations of the conflict tactics scale.

Evidence for the CTS2’s insensitivity to nuances associated with same-gender IPV is located in the previously summarized study by Waldner-Haugrud and colleagues (1997). In their study lesbian women more often indicated being victimized in their relationships than compared to gay men. This finding is consistent with national data indicating that women comprise the majority of those who fall victim to IPV each year (CDC, 2006). However, more interestingly, this study found that women also reported IPV perpetration more

often than did men in the sample. These findings bait two important questions. The first of these questions pertains to whether or not women, particularly lesbians, are more often passive victims but also more often the majority of violent aggressors compared to gay males. A second question focuses on the implications of these findings for gay men: are gay men likely to underreport both using abuse as well as being targeted by an abusive partner? The measure's creators attribute these differences to gender socialization, where men have the tendency to underreport both their use and experience of violence, while women tend to overestimate their actual use of violence (Straus, 1990; Straus et al., 1996). A more thorough discussion of how these gender differences impacted accurate epidemiological findings was discussed earlier in this chapter.

In addition to Straus and colleagues (1996), several other suggestions have been offered to explain the discrepancy in reported IPV victimization/perpetration between lesbian/bisexual women and gay/bisexual men (Ristock, 2002; Stahley & Lie, 1995). Stahley and Lie (1995) confirmed Straus' (1996) gender norm hypothesis. They noted that when compared to gay and heterosexual men who rate themselves on the same violent behaviors using measures like the CTS2, both lesbians and heterosexual women tend to self-report higher levels of violence (as both victims or perpetrators). Ristock (2002) speculated that lesbian women more often self-report both IPV victimization and perpetration at higher levels than men because they often have greater implicit sensitivity to issues of interpersonal violence on account of their tendency to be exposed to feminist-based, antiviolence discourse. Determining alternative explanations for what appear to be

contradictory differences in men and women's scores on the CTS2 cannot be determined based solely on data from the measure. This is primarily due to the CTS2 providing little context in which the phenomena of same-gender IPV can be understood (Ristock, 2002). The CTS2 has been criticized for taking an "all or nothing" approach to classifying individuals within a victim-perpetrator binary without considering contextual factors of violence (Parker, 1990). Cook and Goodman (2006) developed their "Brief Coercion and Conflict Scales" in response to their claim that the CTS2 focuses too much on overt forms of conflictual violence without accounting for the effects of violent tactics that are coercive by nature (e.g., threats, surveillance, humiliation, etc.). This measure is still in development with no known studies having yet employed the measure.

Also ignored by the CTS2 are longstanding patterns of power and control dynamics that exist in a relationship, and no differentiation is made between what Johnson (1995) considers "situational couple violence" versus "intimate terrorism." An individual could, therefore, be misclassified as a "perpetrator" even if this individual reported only one instance of retaliating with violence against a partner who regularly used violence as a strategic method of control.

To refute criticisms that the CTS2 fails to assess the context in which partner violence occurs, the measures' creators stated that such critiques are "analogous to criticizing a reading test for not identifying the reasons a child reads poorly" (Straus et al., 1996; p. 285). However, instead of opting to revise their measure to be more sensitive to contextual factors of IPV, the creators make a case for the administration of the CTS2 in conjunction with other clinical and

behavioral assessment tools. Unfortunately, a “one-tool-among-many” approach to using the CTS2 assumes the measure’s administrator will be familiar enough with dynamics of IPV among same-gender couples that s/he will not have to rely solely on the limited categorizations the measure provides.

When considered in conjunction with the binary-prone tendencies of the CTS2, these suggestions provide stronger evidence that such measures require extra consideration before they are administered to vulnerable populations that include same-gender male couples. The broad employment of the CTS2 presupposes that IPV dynamics and behaviors manifest in the same way between both opposite- and same-gender couples. Moreover, the limited categorization provided by the widely employed CTS2 sustains an essentialist lens through which male-male IPV may continue to be ignored (Ristock, 2002; Johnson & Ferraro, 2000). Some have argued that this essentialist lens continues to influence therapists’ prototypical assessments of situations where IPV is suspected (Blasko et al., 2007).

The Prototypical IPV Behavioral Screener

Prototypicality refers to the process by which a therapist’s personal biases or beliefs about characteristics of the client influences her/his clinical interaction with the client (Blasko et al., 2007). In the case of partner violence, a prototypical viewpoint prevents a therapist from operating outside a myopic understanding of IPV. Such an understanding may be premised on women as victims, males as perpetrators, and one in which same-gender partner abuse does not exist. Such a prototypical viewpoint is sustained through the continued implementation of non-

contextualized approaches to assessment or screening, which are non-iterative and disallow for new conceptualizations of IPV to emerge (Johnson & Ferraro, 2000; Ristock, 2002). Typically, such approaches employ the CTS2, and apply a feminist-essentialist perspective in determining which partner qualifies as the “abuser” and which as the “abused.”

One study was interested in examining the influence of prototypes on clinical assessments conducted by marriage and family therapists (MFTs) (Blasko et al., 2007). The study examined how MFTs’ identification of an IPV “victim” and “perpetrator,” and the attribution of perceived power within the relationship was influenced by the couples’ gender composition (same- versus opposite-gender). Therapists were randomly assigned to read one of three scenarios involving IPV where the gender composition of the couple differed in each scenario (i.e., opposite gender, same-gender female, same-gender male). Of the 347 participants, only five identified as gay/bisexual men, while eight identified as lesbian women. Ninety-two percent of the sample reported having counseled gay male or lesbian clients in the past.

Results indicated that the “victim” and “perpetrator” within each scenario was more frequently identified as *both* partners in the scenarios involving same-gender couples than compared to the scenarios involving opposite-gender couples (Blasko et al., 2007). In addition, the non-initiating partners within both same-gender scenarios were believed to have greater power than the non-initiating partner (a female) in the opposite gender scenario. The authors concluded that practitioners often operate according to a prototypical assessment that is

heterosexist in nature. Moreover, this assessment is aligned with feminist-essentialist notions, those that equate IPV “perpetration” with exclusive male power. In turn, this perspective is rendered inoperative in instances of same-gender male abuse where “perpetration” and “power” cannot so easily default to a male partner. More generally, these findings imply that individuals involved in same-gender IPV may not be viewed as unsafe or insusceptible to harmful consequences compared to opposite-gender couples. Thus, this prototypical paradigm may result in inappropriate treatment recommendations or incredibly dangerous situations for individuals experiencing same-gender IPV (Blasko et al., 2007).

Another important implication of these findings further underscores the insufficiencies of behavioral screening tools that seek to determine the “victim” or the “perpetrator” within specific instances of partner violence (Johnson & Ferraro, 2000). Assessment tools such as the CTS2 perpetuate this prototypical model without allowing for distinctions to be made between intermittent instances of couple violence that may be mutual (i.e., situational couple violence) versus the employment of non-mutual, coercive and controlling uses of abuse (i.e., intimate terrorism) (Johnson, 1995; 2008). Furthermore, such prototypical assessments introduce a prescriptive heterosexist bias that does not allow for new understandings of same-gender partner abuse to emerge (Ristock, 2003). In response to some of these implications, several authors have begun to outline what content and structure should characterize IPV assessment protocols (Greene & Bogo; 2002; Kelly & Johnson, 2008; Ristock, 2002; Rohrbaugh, 2006).

Beyond the Prototypical IPV Behavioral Screener

Those who have examined what has become a prototypical assessment of IPV call for more sensitive approaches to screening for and assessing individuals involved with IPV (Greene & Bogo, 2002; Kelly & Johnson, 2008; Rohrbaugh, 2006). Such recommendations focus on the content areas that should be reflected in these tools, as well as the format and structure of which these tools should consist (Greene & Bogo, 2002; Kelly & Johnson, 2008; Rohrbaugh, 2006). Unfortunately, most of these recommendations are provided based on opposite-gender couples but with recognition that they may also extend to increase the effectiveness of same-gender IPV assessment. Only one of these recommendations bridges the approaches to same-gender IPV (Rohrbaugh, 2006).

In terms of content, Kelly and Johnson (2008) note that IPV screening instruments must focus on identifying different patterns of partner violence—some which may qualify as situational couple violence and others intimate terrorism. As noted by Johnson (2008), violence that is used to coerce and control an intimate partner qualifies as intimate terrorism, and is often characterized by the controlled partner's fear in the abusing partner. Couple violence that may be physical, intermittent, often mutual, and not connected to patterns of control or coercion classifies as situational couple violence. To determine the presence of either form of IPV, some assert that behavioral tools must screen for the following: intensity, frequency, recency, severity and extent of injuries sustained in past instances of violence; patterns and modalities of inter-partner control; the presence of emotional abuse and intimidation; the presence of fear; criminal

records; and the context of violence (e.g., discrete incident of violence, or incident that appears reoccurring across time, topic area, and setting) (Greene & Bogo, 2002; Kelly & Johnson, 2008).

Rohrbaugh (2006) suggests that IPV assessments should also examine specific incidents and acts of abuse, and who initiated the violence and how the partner responded. Although, Ristock (2002) has noted that relying too much on who initiated violence as a moniker of which partner is abusive versus which is victimized perpetuates a “victim-perpetrator binary.” This strategy construes a “victim” from “the one who is abused” to “the one who did not start it” (Ristock, 2002; p. 153). She cautions that this may underplay the actions of the non-initiator, regardless of how abusive, controlling or coercive these subsequent behaviors may be.

A multi-modal approach is a recommended format for IPV assessment (Rohrbaugh, 2006). Kelly and Johnson, (2008) also stress that screening instruments should be gender neutral in choice of language, and include questions about both partners’ violence to be answered by both partners. In such a format in-depth interview data, *en vivo* observations of behavioral cues, and more structured questioning can filter and elucidate subtle nuances of the abuse (Rohrbaugh, 2006). Rohrbaugh (2006) noted the value of interview data and behavioral observations in assessing same-gender IPV, especially in cases where intimate terrorism may be present. For example, individuals who use intimate terrorism often make excuses about their behavior, while those who experience abuse often assume responsibility for the violence perpetrated unto them while

also expressing a sense of shame, and appear to be fearful of their partners (Greene & Bogo, 2002; Rohrbaugh, 2006). Johnson (2006) has underscored the value of more structured behavioral tools, which also ensure that all valuable domains are assessed during an intake interview.

Greene and Bogo (2002) suggested a universal precautionary approach when working with couples; thereby suggesting that therapists screen to detect instances of violence among *all* couples with whom they work. In cases where violence is present in the relationship, the therapist must then determine whether the violence qualifies as situational couple violence or intimate terrorism (Greene & Bogo, 2002; Johnson & Ferraro, 2000).

In terms of structure, four factors have been suggested to distinguish the more common forms of situational couple violence from intimate terrorism (Greene & Bogo, 2002). First, an assessment of the range of control tactics must be made. In this form of the assessment, one is basically attempting to determine what forms of violent behaviors are being used (e.g., physical, emotional/psychological, sexual, identity, etc.). Next, the use of violent tactics to coerce or control a partner is determined by an assessment of each partner's motivation for the use of violence. In this step, a clinician must determine if the purpose of the violence is to instill fear and gain control of a partner or, instead, an intermittent reaction to a specific conflict without the intent to exert control. Third, if physical violence is present, one must assess the impact this violence is having on a partner (regardless of whether this violence is enacted on the partner, a child, or a pet). The clinician must determine what psychosocial or occupational

areas are being impacted by the presence of this violence. Last, a clinician must determine each partner's subjective experience of the other. For example, does one partner appear fearful of the other partner?

In cases where intimate terrorism may be present, a safety assessment should also be conducted. This safety assessment may be informed by a question such as, "Presently, how safe do you feel in relationships with people close to you?" Following the safety assessment, one should help individuals develop plans to ensure their day-to-day safety. Nowhere in the literature does it advise that those who are targets of abuse should attempt to leave their abusive partners. This is likely due to the great risks associated with leaving one's partner without an effective safety plan in place (Rohrbaugh, 2006).

Moving beyond a prototypical approach to behavioral assessment has implication for structural change. Specifically, adopting a more context-based approach to understanding the iterations of same-gender IPV has potential for transforming the policy-based status quo. As Ristock (2002) noted, the research conducted that is prototypical by nature impacts policy around treatment and service provision to individuals involved in IPV. For instance, the federal or state funding of mental health providers in private practice or in community-based settings is often contingent on what has been referred to as "necessary speech" (Ristock, 2002; 2003). This necessary speech mandates that providers only serve the "victim" or "perpetrator" of IPV. Those labels are most often determined through the use of acontextual measures such as the CTS2 (Johnson, 2008; Ristock, 2003). As pointed out by Johnson (1995), such measures were normed

on large randomly selected samples of the general population, and therefore may not accurately reflect the needs of individuals/couples who present in clinical settings. Current research must now challenge the “absent standard” that currently maintains the status quo of behavioral assessment (Sampson, 1993). I conclude this chapter by presenting a rationale for why this dissertation study examined a set of important research questions.

Rationale

Intimate partner violence (IPV), one of the largest social issues impacting couples and families throughout the US, is considered to be among the three largest health problems facing gay/bisexual men today (Island & Letellier, 1991; Oatley, 1994). IPV may manifest in many overt and more subtle forms of abuse that can take the form of being physical, psychological/emotional, sexual, and financial/economic (Dobash & Dobash, 1984; Follingstad et al., 1990; Martin, 1976; Walker, 1979). Occurring more often among same-gender male couples are less well-documented forms of abuse, including those that are identity and HIV-related. IPV has been associated with several long-term psychological symptoms including anxiety, depression, drug and alcohol dependence, eating disorders, self-injurious behavior, and suicidal ideation (Campbell, 2002). However, few studies have documented the effects of IPV, and the patterns and forms to which it manifests among same-gender male couples (Houston & McKirnan, 2007; Merrill & Wolfe, 2000).

Literature pertaining to IPV in the US has generally ignored the presence and important context of violence among same-gender couples. In my critical

review of the state of the science I underscored the overall paucity of rigorous and sensitive research methods utilized among samples of same-gender couples, as well as the application of theoretical conceptualizations that were originally developed for use with heterosexual women. Such conceptualizations are often rendered inoperative when applied to understanding women who use abuse, or men who experience violence.

The field of IPV research and practice has only begun to understand same-gender IPV. This is due, in part, to prototypical IPV behavioral screening and assessment approaches that are largely heterosexist, and fail to capture the important contextual factors that may be unique and specific to same-gender male IPV. Moving beyond a prototypical framework is essential to properly understanding same-gender IPV, and essential to tailoring therapy and research approaches that foster healthy, same-gender male relationships.

While much can be learned and applied from the notable scholarship and advocacy conducted by and among heterosexual female survivors of opposite-gender IPV, culturally responsive research among LGB survivors of IPV is necessary. Specifically necessary is applied research aimed at preventing IPV among same-gender couples and at intervening to help facilitate healing among all survivors of same-gender IPV—those who use abuse as well as those who are targeted by it.

This dissertation consisted of two sub-studies, both of which were applied in nature and focused on improving the accuracy and culturally-responsive way with which mental health providers screen and assist men in same-gender

relationships involving violence. In Study One, I investigated how IPV unfurls in the context of same-gender male relationships, and what methods are considered both effective and unsuccessful when screening for it. Using qualitative methods—focus groups and in-depth, individual interviews—I met with key informants who could be categorized into two general cohorts of individuals: gay/bisexual males who had been in romantic relationships involving IPV, and mental health providers with varying degrees of experience serving this population.

The purpose of Study Two was to create then refine a multi-dimensional behavioral screening tool that mental health providers can utilize with male clients who are (or have been) in same-gender relationships that are violent. Through the use of similar qualitative methods described earlier, key informants in the second study provided me with their insights on the creation and refinement of the screener's content, format, and structure. Based on the preceding review of the literature as well as the description of the study aim, I developed the following research questions to guide each study within this investigation.

Research Questions

1. How do gay/bisexual men who have been in IPV relationships define IPV in the context of same-gender relationships?
2. How do IPV-related mental health providers define IPV in the context of same-gender relationships?
3. What are the partnership dynamics within a male same-gender relationship where IPV is present?
 - a. What aspects of these relationships *fit* the traditional victim-perpetrator dynamic?
 - b. What aspects of these relationships *do not fit* the traditional victim-perpetrator dynamic?
4. What are some of the contextual factors that contribute to same-gender IPV among same-gender male couples?
5. What *topics* should be included in a behavioral assessment of same-gender IPV among males?
6. What *content* should be included within a measure to assess same-gender IPV among males?
7. How should a measure to assess same-gender IPV among males be *structured and formatted*?

CHAPTER II

METHOD

As I emphasized in the previous chapter, much of the research on intimate partner violence (IPV) to date has focused on supporting the needs of individuals who comprise the statistical majority of IPV victims and survivors—heterosexual, opposite-gender couples. Little attention has been paid to screening for the presence of IPV among same-gender couples. The aim of the current investigation was to determine the essential components of a behavioral tool for screening individuals in same-gender male relationships involving violence. I addressed this aim and related research questions by involving participants whose backgrounds I will explain further in the subsequent section of this chapter. Each of these groups of key informants participated in up to two studies of which this project is comprised.

I will briefly describe the overall dissertation study before further discussing its participants and procedures. This dissertation investigation consisted of four separate stages, of which only two of these stages involved the direct participation of key informants. The first stage of the study consisted of initial qualitative data collection across two groups of key informants. In the study's second stage, I analyzed and constructed the preliminary content, structure and format of a behavioral screening tool for same-gender male IPV. In the study's third stage, I invited key informants (both previous and newly enrolled) to participate in individual interviews and focus groups where they provided me with their feedback on the constructed measure. The final stage consisted my

refinement of the tool based on data I gathered and analyzed in Stage Three. See Appendix E for a diagram of Stages One to Four.

Research Participants

A total of 33 men in same-gender relationships involving violence (MSRV) were screened for study participation. Of those screened, 20 MSRV were determined to be eligible for study participation. Sixteen of the 20 eligible MSRV chose to enroll in the study. A total of 17 mental health providers (MHP) were screened for study participation, 16 of which were eligible, and a total of 10 agreed to participate.

Participants could be categorized into two general cohorts of key informants: (1) gay/bisexual male participants who had been in romantic relationships involving IPV, and community mental health providers with varying degrees of experience serving this population. Within these two general cohorts are four subgroups of key informants: MSRV who have (a) sought help from a mental health provider ($n= 9$) or (b) not sought help from a mental health provider ($n= 7$), and mental health providers who (c) have served this population ($n= 7$) or (d) had very limited practice experience related to gay/bisexual males and/or IPV issues ($n= 3$). Table 1 is comprised of sociodemographic characteristics from these two groups of key informants across all study stages. Experienced MHP were defined as those who had worked for at least one year in therapy or counseling settings with males involved in same-gender IPV—a standard outlined by the American Psychological Association’s training guidelines (APA, 2008). Providers who did not meet this requirement were considered less experienced.

Regardless of their degree of experience, all MHP participated in focus groups; however, these groups consisted of individuals with similar degrees of experience working with same-gender male IPV.

For two notable reasons, I conducted individual in-depth interviews as a preferred approach to data collection with males involved in same-gender. The first reason was a precautionary one: the men who self identified as “victims/survivors” of IPV may not have felt comfortable attending a group-based format (e.g., focus group) knowing that self-identified “perpetrators” may have also been present. The second reason for this individual interview format was to ensure that all participants’ confidentiality was assured, and that they each felt comfortable disclosing with me sensitive information about which they may have felt shame.

I gathered the study sample through convenience from LGBT organizations throughout central and northern Illinois, a heavy concentration of which were Chicago-based. Each of these organizations featured programming that either attracted men in same-gender relationships, or addressed LGB intimate partner violence specifically. As a means of promotion, I posted study information on IPV-related listservs and targeted phone and email communication to known MHP who worked with individuals who were involved with same-gender IPV. I also posted fliers describing the study in various establishments (e.g., businesses, community-based health organizations, bars/clubs, etc.) that were frequented by gay/bisexual males. All study visits were conducted in private facilities located within DePaul University’s Department of Psychology and Howard Brown Health Center.

Table 1. Sociodemographic Profile of Key Informants by Stage

	<u>MSRV-Stage 1</u>	<u>MSRV-Stage 3</u>	<u>MHP-Stage 1</u>	<u>MHP-Stage 3</u>
n	9	12	2 (7 participants)	2 (7 participants)
Pts. unique to Stage 3	--	7	--	3
Mean Age (SD)	46.67 (9.27)	42.83 (15.14)	39.14 (9.08)	39.28 (10.96)
Gender (%)				
Male	9 (100)	12 (100)	4 (57)	2 (29)
Female	--	--	3 (43)	5 (71)
Race/Ethnicity (%)				
African American	5 (56)	9 (75)	--	1 (14)
European American	3 (33)	3 (25)	7 (100)	6 (86)
Latino	1 (11)	--		
Sexual Orientation Identity (%)				
Gay/homosexual	8 (89)	11 (92)	4 (55)	3 (43)
Lesbian	--	--	1 (14)	1 (14)
Straight/heterosexual	--	--	1 (14)	2 (28)
Bisexual	1 (11)	1 (8)	1 (14)	1 (14)
Education Level (%)				
Jr. High	1 (11)	1 (8)	--	
High School	1 (11)	5 (42)	--	
Some College	1 (11)	2 (17)	--	
College Degree	2 (22)	1 (8)	1 (14)	1 (14)
Grad/Prof Degree	3 (33)	1 (8)	6 (86)	6 (86)
Missing	1	2		
Form of IPV-related Training (%)				
Clinical Practicum			--	1 (14)
40-hour IL DV Training			1 (14)	--
Continuing Education			--	1 (14)
Antiviolence Organization			3 (43)	2 (27)
LGBTQ Organization			1 (14)	--
More Than One from Above			2 (29)	3 (43)
Received Male-Male IPV Training			4 (57)	2 (29)

I conducted a brief screening measure with all individuals who were interested in study participation. This measure consisted of screening items particular to each group of key informants. Volunteers screened for participation in the first stage of in-depth interviews (i.e., Stage One) were considered eligible if they: resided in Illinois, had a history of being in a same-gender IPV relationship (e.g., relationship less than 6 months, relationship between 6 to 12 months; relationship greater than 12 months); had sought professional support related to their involvement in a same-gender IPV relationship (e.g., less than 10 sessions; 10 to 20 sessions; more than 20 sessions within a one year period), and recalled participating in a screening process that pertained to an abusive relationship. Volunteers screened for participation in the first stage of focus groups (i.e., Stage One) were considered eligible if they: were licensed and practiced in Illinois, were a provider from a mental health or behavioral intervention background (e.g., psychologist, counselor, social worker, or other behavioral interventionist); and, confirmed they had experience conducting some form of behavioral screening with males who had experienced same-gender IPV. If determined to be eligible, each of these two groups of participants was consented to participate in both Stages One and Three of the study. In the third stage of data collection, I widened the eligibility criteria to include two new groups of key informants whose attributes were slightly distinct from participants enrolled at Stage One.

Specifically, I widened Stage Three eligibility criteria by not requiring newly recruited men (i.e., those who had been in same-gender relationships involving violence) to have had previous experience seeking professional help for

issues related to IPV. My rationale for this widening of inclusion criteria was that unique and valuable insights regarding the preliminary behavioral screening tool would be gathered from men who have experienced same-gender IPV but who had not sought the help of a MHP. I considered this feedback to be distinct from the feedback shared by the men who participated in Stage One, and therefore relevant for ensuring the validity of this measure. As in Stage One, these men participated in individual in-depth interviews (to retain their privacy and safety).

Similarly, I widened the Stage Three eligibility criteria to include MHP who either (1) had professional experience working with gay/bisexual men but who did not have experience working within the field of IPV, (2) MHP with professional experience working in the field of IPV but who did not have experience working with gay/bisexual men in IPV relationships, and (3) MHP with no professional experience working with IPV issues or with gay/bisexual male clients. I chose to include this population of MHP to provide valuable insights into the broader utility of this tool for MHP with limited practice experience in screening IPV and/or male-male relationship issues.

Several exclusion criteria applied to the sample at large. All respondents were considered ineligible if they were under 18 years of age, were non-English speaking, or appeared intoxicated, or cognitively or emotionally unsuited for participation at the time of their screening. Also, study participation was prohibited if it threatened to jeopardize the personal safety of any potential participant.

Measures

I determined the eligibility of all volunteers who were interested in participating in the study by administering an *eligibility screening measure* (Appendix F). The measure remained anonymous (i.e., de-identified) for volunteers who were ineligible to participate, or for eligible volunteers who declined participation. When applicable, I asked MHP I screened to indicate the settings in which they had provided therapy/counseling services to males involved in same-gender IPV. I then assigned a participant number and designated as confidential the completed screening measures of those who were eligible and agreed to participate in the study. I filed the completed screeners of enrolled participants and any de-identified participant data (i.e., de-identified interview or focus group transcripts) separately from each other. Following completion of the eligibility screening interview, I conducted an informed consent whereby each participant and I privately reviewed and signed acknowledgment of study activities, their purpose, risks, benefits, and compensation.

Upon completion of informed consent, I gathered participants' contact information through the use of the *Contact Information Sheet* (Appendix G). This confidential tool inquired about personal contact information, as well as the contact information of close and trusted others. I assured all participants that their completion of this form was voluntary, and that it would only be used to re-establish contact with them to re-engage participation in Stage Three of the study.

Between Stages One and Three a total of four interview subjects and three focus group members were lost to follow-up. Participants enrolled at Stage Three

of the study also completed a Contact Information Sheet (although they only participated in one stage of the study) to ensure they were reachable at the time of their study visit date.

I facilitated individual interviews, conducted in Stages One and Three, through the aid of a semi-structured *guide for the in-depth interview* (Appendix H). This guide was structured to align with the aim and research questions of both Study One (i.e., to understand same-gender IPV) and Study Two (i.e., to develop a behavioral assessment tool for same-gender male IPV). Thus, an example question pertaining to Study One is, “In your opinion, what are the forms of abuse that are faced by males involved in same-gender intimate partner violence?” An example question pertaining to the purpose of Study Two is, “Based on your experience, what content would you include in a measure of same-gender male IPV?”

I facilitated group discussion among MHP (in Stages One and Three) through the use of a semi-structured *focus group guide* (see Appendix I). Like the interview guide, the focus group guide was structured to align with the aim and research questions of both Study One (i.e., to understand same-gender IPV) and Study Two (i.e., to develop a behavioral screening tool for same-gender male IPV). An example question pertaining to the aims of the first study is, “In your opinion, what are the common forms of abuse involved in male same-gender IPV?” An example question pertaining to the purpose of Study Two is, “Based on your experience, what content would you include in a measure of same-gender male IPV?” I encouraged key informants in each focus group to discuss their

clinical experiences while also reminding them of their ethical obligation to uphold the confidentiality of their former or current clients.

Following their participation in Stage One of the study, all key informants completed a confidential, self-administered paper-and-pencil *questionnaire* (Appendix J). The questionnaire included questions pertaining to demographic information (i.e., age, sexual identity, ethnic identity, and education). In addition, the questionnaire provided all participants with the opportunity to share additional thoughts related to any of the content explored during the qualitative component of Stage One. Additional closed-ended items inquired about the training of MHP who participated in the study.

The *Assessment Feedback Guide* (Appendix K) assisted in facilitating interviews and focus groups in Stage Three of the study. An example question on this guide is, “Based on your experience, what content would you add to this measure of same-gender male IPV?” It is important to note that questions were added to this guide based on specific findings that emerged from the findings of Study One.

Procedure

As the Principal Investigator of this dissertation study, I determined eligibility for inclusion in the study either in-person or by phone. In cases where study inquiries were made about the study via telephone or e-mail I conducted a brief screener via telephone. I then re-conducted screener in-person to ensure eligibility of the previously screened individual. Upon determining study eligibility, I obtained informed consent from each participant. During the consent

process, I informed participants that the interviews or focus groups in which they participated would be digitally recorded and later transcribed verbatim. I also assured participants that all identifying information (e.g., names, addresses) mentioned during their participation would be omitted once transcribed, and that participation in the study was strictly confidential. Following their informed consent, I scheduled participants to complete at least one study visit (or up to two for those enrolled in Stage One of the study). As mentioned the participant activities occurred across two studies of this project.

Study One

In Study One of this project, I conducted individual in-depth interviews and focus groups. Given the stigma and potential discomfort associated with disclosing involvement in an IPV relationship, key informants who had been in relationships involving same-gender male IPV completed an individual in-depth interview lasting up to one hour. In contrast, and to help facilitate discussions around treatment, key informants who were MHP participated in one of two 2-hour long focus groups that each consisted of 3-4 MHP. All key informants completed a questionnaire that took approximately 3-5 minutes to complete. I digitally recorded and transcribed verbatim (with the exclusion of identifying information) all individual interviews and focus groups, which assisted me in qualitative analysis. I secured within a password-protected drive all transcribed data. Moreover, I destroyed all digital files containing both interview and focus-group recordings upon their transcription. I also secured data from the questionnaire within a password-protected drive, and within a password-protected

software file (e.g., SPSS). I destroyed hard copies of the questionnaire upon it being entered in SPSS. Completion of either an interview or focus group, and a questionnaire concluded each key informant's participation in Study One.

Study Two

Following their participation in Study One (consisting only of Stage One), I analyzed all the qualitative data and constructed the preliminary model of a behavioral screening tool of same-gender male IPV. This data analysis and screening tool construction composed the contents of Stage Two. The analytical and screening tool construction procedures I conducted (see Appendix E) consisted of the phenomenological analysis of transcribed interviews and focus groups from Study One (Miles & Huberman 1994). In this procedure I incorporated an *emic*, or contextualized, approach to understanding the phenomenon under study by ensuring that patterns, themes, and categories of analysis emerged from the data (Denzin, 1993; Miles & Huberman, 1994; Patton, 2002).

I based the procedure for measure development on two sources. The first of these was a recent compendium of assessment tools published by the Centers for Disease Control and Prevention (2006), which assisted me in the development of the measure's format and structure. This compendium includes an array of scales developed for researchers and MHP interested in measuring opposite-gender IPV "victimization" and "perpetration." The Revised Conflicts Tactics Scale (CTS2) is among the measures included in this compendium. The second source was a participatory model utilized to develop suitable content for a

measure of IPV among heterosexual women (Adams, Sullivan, Bybee, & Greeson, 2008). The details regarding how qualitative data from Study One informed my development of the content of the measure is described in more detail in Chapter Three.

After completing data analysis and preliminary screening tool construction in Stage Two, I invited all participants who participated in Stage One of the study to return and participate in Stage Three. As previously stated I also enrolled a new wave of participants whose backgrounds fit within widened inclusion criteria, and who consented to participate in only Stage Three of the study.

At this point, and through the same modalities used above (i.e., individual in-depth interviews and focus groups), participants were asked to evaluate the constructed measure aided by the assessment feedback guide already described. Given the distinctive attributes of interview participants versus focus group participants, my procedures for obtaining feedback on the instruments varied by key informant type.

To assist in the review of the tool's content, structure and format, I began each focus group by conducting a role-play where I played a therapist using the screening tool with a potential client (played in most cases by a male colleague). I provided each of the focus group members with hard copies of the measure and, after the role-play exercise, instructed them to respond to items on the *Assessment Feedback Guide* (Appendix K) which I had written on large newsprint in different areas of the room. I also provided them with the ability to take notes on their copy of the screening tool as well as other notepaper.

With MSRV who participated in in-depth interviews, I reviewed the flow of the tool by conducting a role-play where participants played the part of themselves at the first occasion of their meeting with a therapist regarding experiences of same-gender IPV (when applicable). I asked those with no such prior experience meeting with a therapist to imagine being in such a meeting. To all participants I acknowledged the potential emotional discomfort associated with such an activity and I offered two alternative methods of reviewing the screening tool. These alternative methods included: (1) continuing with a role-play exercise but with their portraying an individual whose story was different than their own, (2) interchanging the role-play exercise for a more traditional approach to reviewing the screening tool with no role-play component.

Five of the twelve MSRV who participated in Stage Three chose to participate in a role-play where they reenacted their first experience in a therapeutic setting discussing issues of same-gender IPV. Seven participants had no prior experience in therapy related to IPV-exposure. Of these seven, six chose enact a role-play premised on how their particular situations would unfold in a first meeting with a therapist. One participant chose to review the screening tool in a more traditional manner due to feelings of discomfort with re-enacting aspects of his current relationship in which partner violence was reportedly present. Regardless of their chosen method, I asked each participant to consider the utility of the tool from the perspective of a male who may be in a relationship like their own. This approach complemented the *emic* nature of my investigation, and helped ensure a sense of the tool's acumen, cultural-responsiveness, and

sensitivity for screening men who report being in same-sex relationships involving violence.

All key informants (in Stages One and Three) were paid \$20 (cash) per study visit as compensation for their time and participation. In addition, participants who demonstrated a need for transportation support were provided with fare cards for public transportation. Following participation in both Stages One and Three, I debriefed all participants using a *debriefing script* (Appendix L) after which time I provided referrals for mental health and other social services to those who expressed an interest in receiving such information. To ensure the safety of participants and others, the debriefing script also outlined procedures for reporting occurrences of current abuse as well as suicidal or homicidal ideation (Appendix L).

The process of eliciting participatory feedback from key informants characterized a process of data *triangulation*. Triangulation is a strategy to enhance the rigor and quality of qualitative data analysis. In this case triangulation allowed for a diversity of perspectives on the developed measure while also strengthening confidence in whatever phenomenological patterns were reflected in the measure (Lincoln & Guba, 2000; Patton, 2002).

The final stage (i.e., Stage Four) consisted of my refining the developed instrument through suggestions provided by Stage Three participants. An analytical approach less phenomenological than Stage Two was employed in Stage Four, as the aim of this stage was to incorporate key informant feedback to refine the behavioral screening tool (Adams et al., 2008; Cook & Goodman,

2006). The specific procedures for all forms of analysis are discussed in Chapter Three. The constructed behavioral tool was considered complete after I made all suitable changes recommended by MHP and MSRV key informants.

CHAPTER III

RESULTS

The participatory design of this project yielded an opportunity for the screening tool construction to be developed from the lived experiences of key informants who participated in each of the project's two studies. The aim of Study One (i.e., Stage One) was to develop a greater understanding of intimate partner violence (IPV) as it occurs in same-gender male relationships. The aim of Study Two (i.e., Stages Two, Three, and Four) was threefold: (1) to determine suitable content for a multi-dimensional behavioral tool to assist mental health providers (MHP) in screening for same-gender IPV in adult males, (2) to develop a preliminary draft of the screening tool, and (3) to refine the screening tool through the qualitative feedback provided by mental health providers and men who have been in relationships involving same-gender IPV.

Atlas.ti software, Version 6.0 (Atlas.ti, 2008) assisted me in the organization of the qualitative data. In addition to qualitative data, a brief survey instrument was included to provide a descriptive demographic profile of each participant (e.g., age, ethnicity, education, etc.). The analysis of these quantitative data was limited to simple frequencies and cross-tabulations that assisted in my comparative analyses (described later in this chapter). All collected data were de-identified, then entered and stored within an appropriate, encrypted data management software program (e.g., Atlas.ti and SPSS).

This chapter begins with a description of the procedures that guided both Study One and Study Two of this dissertation. Following the description of these

procedures, I outline and synthesize the phenomenological findings of Study One, which was comprised of Stage One. Next, outlined the findings from Study Two, which consisted of three final stages of this dissertation: Stages Two, Three and Four. Beginning with Stage Two, I provide a description of the preliminary behavioral screening tool, with an incorporation of how the elements of this screening tool were informed by findings from Stage One. Next, I highlight findings from Stage Three of the study, which consisted of interviews and focus groups where key informants provided feedback about the preliminary screening tool. I conclude this chapter with a brief description of the finalized behavioral screening tool refined in the final stage of this dissertation (i.e., Stage Four).

Study One Analysis Procedures

The qualitative analysis of data I gathered in Study One was phenomenological in nature (Denzin, 1993; Miles & Huberman, 1994). This approach to qualitative data analysis depends on the development and refinement of a coding structure that accurately represents the phenomena under study. *Codes* refer to the units of meaning assigned to any given text (Miles & Huberman, 1994; Patton, 2002).

Unlike quantitative designs, where data collection predates analysis, it is ideal that the collection and analysis of qualitative data co-occur and inform one another (Miles & Huberman, 1994). Thus, as an iterative process, qualitative data analysis is procedurally quite different from quantitative analysis (Patton, 2002).

I conducted six phases of analysis in this study. These six phases assisted me in framing the investigation around the research questions particular to this

study. In order, these phases included: (1) documenting my immediate post-data collection impressions, (2) reading through entire transcripts, (3) content coding, (4) initial thematic coding, (5) coding refinement, and (6) cross-case analysis (Miles & Huberman, 1994). Provided below are descriptions of each of these phases and examples of how I applied them to the phenomena under study.

Documenting Impressions from Study Visits

My initial familiarity with the data involved my experience of conducting the individual interviews and focus groups. Immediately following each of these data collection periods, I drafted approximately one page of notes highlighting the most salient themes from the interview or focus group. These themes related to the research questions, and also to my behavioral observations of the participant/s while in the sessions.

Reviewing Transcripts

To ensure a general understanding of the participants (e.g., sociodemographics) and their overall experiences, I read the entire transcription of an interview or focus group at least once before beginning any additional coding procedures. Although the primary interest of the study related to relationships involving IPV, it was important to understand the greater experiences of participants that may or may not have appeared to directly relate to the primary topic (Miles & Huberman, 1994). For example, in an individual interview, some participants tied their family of origin dynamics to why they became involved in an IPV relationship. In another example, MHP interweaved case stories from opposite-gender couples as a means of underscoring pertinent

issues related to same-gender IPV. After completing this procedure, I began my second phase of phenomenological examination: content analysis.

Content Analysis

In content analysis, I read the interview and focus group transcripts with no strict guidelines other than to identify all ideas or concepts relevant to the research questions. This procedure was repeated with additional sets of transcripts until I could no longer identify additional sets of concepts related to the research questions (Miles & Huberman, 1994). After the completion of content analysis, my analysis of relevant themes within the identified content areas followed.

Thematic Analysis

My third phase of data analysis consisted of thematic analysis. The aims of this step were to delineate more precise descriptions of themes based on the synthesis of concepts I identified during content analysis. In this phase I assigned thematic codes to units of text that reflected phenomena of interest (i.e., text related to the research questions) (Miles & Huberman, 1994; Patten, 2002). In the case of this study, an emergent theme related to the use of the Conflict Tactics Scale (CTS2) during assessment was coded simply as “CTS2”.

Coding Refinement

After assigning thematic codes to relevant concepts in the interview, I began a process of coding refinement. This process consisted of my highlighting subsets of codes that existed within those themes identified through thematic analysis. For example, at one point I delineated the thematic code “CTS2” in order to reflect its use in assessing a participant who had experienced IPV. To do

so, I modified the thematic code “CTS2” to reflect its use to determine IPV victimization (as opposed to perpetration) (e.g., “CTS2-Victimization”). As the primary reviewer of data, I continued this refinement process until all sub-themes relevant to the research questions were represented (Miles & Huberman, 1994).

Cross-case Analysis

Once my thematic analysis had clarified each concept and their sub-components had been refined, I began cross-case analysis. In cross-case analysis, I examined similar experiences across participants aimed at determining a consistent pattern relevant to the research topic (Miles & Huberman, 1994). It is also during this time that I triangulated the qualitative data with quantitative data. For example, to understand how a given factor (e.g., financial stability) influenced an individual’s ability to maintain a therapeutic relationship, I compared all the interview data wherein participants discussed their financial status. I then compared these data to data from the questionnaire (e.g., education level). Quantitative data also suggested further or unique stratification strategies in the sample based on sexual identity or ethnic/racial identity. I then interpreted these comparative findings through the creation of descriptive meta-matrices, semantic tables, and coding diagrams. Compared to Study One, my analysis procedures for Study Two were less phenomenological by nature.

Study Two Analysis Procedures

My analysis procedures in Study Two focused solely on refining the behavioral screening tool—a tool that I developed following my analysis of qualitative data I gathered in Study One. The analysis procedures I conducted in

Study Two were informed by a recent study that developed a screening tool for the occurrence of economic abuse among heterosexual female “survivors” (Adams et al., 2008). Adams and colleagues (2008) developed their measure through participatory means, where the knowledge of IPV researchers, advocates, and “survivors” were tapped at multiple points in the research project. Specifically, IPV researchers and advocates assisted in the development of items for the measure, while the contributions of “survivors” were limited to piloting the developed measure. Similar to Adams and colleagues (2008), my study incorporated feedback from study participants. However, in my study, equal feedback was elicited from individuals who had professional as well as personal experiences dealing with issues pertaining to IPV.

Triangulation

As previously mentioned, qualitative feedback on the developed measure underwent a method of triangulation. This method of triangulation consisted of three components of analysis that were non-discrete, and iterative by nature. The first component consisted of my creation of a measure based on data gathered from Study One. The second and third components of analysis, respectively, consisted of feedback on the developed measure provided from interviewees (i.e., gay/bisexual men who have been in same-gender IPV relationships) and focus group attendees (i.e., mental health providers).

Here, the strength of the iterative aspect of qualitative analysis is demonstrated, as feedback data collected from participants in Study Two informed my refinement of the behavioral assessment. Aside from yielding a great

deal of accuracy and attention to context, this iterative method of analysis helped ensure the internal validity of the measure (Patton, 2006). This method also complemented the iterative nature of qualitative analysis as a whole.

In the final component of this analytic description, I briefly describe how the credibility of the study findings was enhanced. These procedures included negative case analysis and strategies I employed to manage my internal bias during the process of data collection.

Negative Case Analysis

Data analysis resulted in my identification of various trends and patterns related to the aims and research questions of this study. My understanding of these trends and patterns was increased through *negative case analysis*, or the examination of data that did not share properties characteristic of the majority of data. Patton (2002; P. 554) described data from negative case analysis as the “exceptions that prove the rule” insofar that they allow the researcher to further refine study conclusions. Employing this form of analysis involved my examining of data whose findings were inconsistent with patterns from other data, the literature, or data that did not align with assumptions of my research questions. In my examination of these data, I utilized an *emic* approach to examine the context by which inconsistencies emerged.

Managing Internal Bias

In addition to negative case analysis, I assured the credibility of my data and analyses by regularly engaging in processes to manage my internal biases. These processes included self-reflection, composing field notes, and peer

debriefing. Specifically, I engaged in a process of self-reflection regarding my socio-historic background, experiences in my current and previous intimate partnerships, experiences in lesbian, gay, bisexual, and transgender (LGBT) communities, and motivation to investigate the phenomena under study.

Self-reflection.

Prior to and throughout data collection, I reflected on my personal background and examined how aspects of my personal narrative influenced my interest in pursuing this research topic. My personal reflection resulted in a narrative in which I earnestly engaged and reflected upon while collecting and analyzing data. This reflexive process was similar to that described by Lincoln and Guba (1985), and helped ensure that the data were most accurately reviewed based on participants' shared experiences, and not my biases as a research-practitioner.

At the time of data collection and analyses I aged from 29 to 31 years old. I also began to reside with another male to whom I remained in a committed, monogamous relationship throughout the course of this study. Other aspects of my personal background and history remained constant throughout this study. For example, I continued to identify as Mexican American, male and gay. Neither in my current relationship nor in any previous relationships have I experienced violence *from* nor used violence *against* an intimate partner. I was raised in a dual-parented, lower middle-class home in Southern California. During my childhood and through adolescence I do not recall witnessing any forms of IPV

between my parents, nor between other family members and their intimate partners.

My interest in conducting this dissertation research stemmed from my five years' experience volunteering as a therapist within a community-based program funded to work with "survivors" of same-gender intimate partner violence. My work in this program consisted of seeing male and female clients individually, in the context of psychotherapy groups, and in psychoeducational support group settings. Approximately five years ago I co-founded an outpatient therapy group within this program, which is typically composed of 8-10 males who have experienced same-gender IPV. I co-found this group after noting that no such group had existed in the Chicagoland area since approximately 2002.

The demand for this group was astonishing. Yet, soon after beginning the group I became interested in how many male clients expressed feeling that terms like "victim" or "survivor" were misnomers to their experience. The men with whom I worked felt these terms were non-reflective of their experiences in abusive relationships. Most often, they had described how the influences of societal norms and cultural messages regarding IPV left them feeling as though labels such as "victim" or "perpetrator" did not truly capture who they are, or what they have experienced. Moreover, as a mental health provider, I often feel fettered by the predominant vernacular of the anti-violence movement. I often question certain assumptions that many mental health providers (MHP) and IPV advocates hold dear. For example, *are all forms of violence that manifest in a same-gender male couple always controlling and coercive by nature? Can a man*

who is in a same-gender relationship involving violence be considered both a victim and a perpetrator of violence? If so, how can a contextualized screening determine the extent to which he is using versus experiencing partner violence?

Over the course of this study I have learned that questioning certain assumptions endorsed by MHP is necessary when attempting to address an understudied phenomenon like same-gender IPV in males. My inquiries have resulted in meaningful discussions within the context of focus groups, and these discussions have directly influenced the creation of the screening tool developed in this study.

Composing field notes.

Qualitative research, like other methodological designs, is susceptible to biases on the part of the researcher. To prevent my personal biases from influencing the conclusions that I drew from these data, I composed field notes during and after each incident of data collection. Within these notes I included my feelings, reactions, ideas, and initial reflections about everything I experienced immediately prior to, during, and immediately following an interview or focus group. I also recorded objective details regarding such meetings (e.g., “interview lasted 1.5 hours”).

According to Creswell (2008), the researcher’s *en vivo* notation of her/his thoughts, behaviors, and activities during data collection serves as a key element of qualitative observations. These notations were referred to throughout the data collection process. I considered my notations to be contextual elements that influenced my reactions to the participant, or the data s/he shared. For example, I once completed a *post hoc* field note that read “I feel irritated by participant who

arrived to focus group 35 minutes late [*sic*].” This notation underscored how my feelings and reactions to the tardy participant may have influenced my interaction with this individual, as well as my analysis of what the individual shared during the focus group. As a result I decided to enlist my peers in debriefing about a set of codes that emerged from that particular focus group to ensure that my personal feelings were not influencing the way in which these data were interpreted. I will briefly highlight this process, referred to as *peer debriefing*.

Peer debriefing.

In addition to writing field notes, I also performed peer debriefing with colleagues and peers, including those who had little research or clinical experience with gay/bisexual men and/or IPV. These debriefings allowed me the chance to verbalize phenomena that emerged from the data, and question how I developed my preliminary conclusions. In most cases, I stayed grounded in the data and imposed little of my personal history or biases. When these biases arose, however, I resolved them by carefully reexamining the data beginning from the second analytic phase of reading the transcript over again. I also re-enlisted my peers in a debriefing process that allowed me to vocalize the logical analysis through which my conclusions were developed. The various activities I have described assisted me in managing my internal biases, and ensuring the validity of the study’s results. I begin to describe these results in the subsequent section of this chapter. The results are presented according to the study from which they emerged. I begin with results from Study One.

Study One Results

The findings from qualitative data collected in Study One are organized according to both the aims and guiding research questions of this first stage. I first share how the two groups of key informants active in this study—mental health providers (MHP) and men who have been in same-gender relationships involving violence (MSRV)—defined and identified the phenomenon of intimate partner violence (IPV) in same-gender male relationships. I then highlight participants’ challenges to either implementing or having undergone an initial same-gender male IPV screening. I also share participants’ recommendations for an effective behavioral screening tool to assess same-gender IPV.

Accompanying the presentation of each theme are qualitative data in the form of quotes, which I have included to characterize each theme. All names and locations that were referenced by participants during each interview or focus group have been modified within the transcribed data (i.e., assigned pseudonyms) to ensure the confidentiality of participants, intimate partners, clients, colleagues or other individuals who may have been identified. When highlighting findings from MSRV interview data, “R:” refers to the respondent (i.e., the MSRV) while “I:” refers to myself as the interviewer. I have included a brief demographic profile of MSRV following each of their featured characteristic quotes. The profile highlights the participants’ pseudonym, age at data collection, ethnic/racial identity, and self-assigned sexual orientation identity (e.g., “Jack, 35, African American, bisexual”). Quoted data of focus group interactions may include exchanges consisting of multiple quotes from two or more participants. To spare

the redundancy and immoderation of including a detailed demographic profile after each quote, a brief demographic identifier that includes pseudonym and age precedes quoted focus group members (e.g., “Dawn, 39:”). The Study One results begin with a presentation of how IPV was defined by both groups of participants—MSRV and MHP who have served this population.

Defining Same-gender Male IPV

In defining IPV participants highlighted the presence of several major themes related to the diagnostic elements of which IPV is comprised. These themes included beliefs regarding a) the etiology of IPV, b) power and control imbalances between partners, c) the ways in which controlling behavior is patterned within a relationship, and d) the role of fear in relationships involving IPV. In addition, participants presented their beliefs regarding what forms of violent behavior constitute IPV.

Regarding how they came to be in a relationship involving IPV, MSRV endorsed personal beliefs that aligned with a *social modeling etiology* of IPV. These beliefs most often surfaced when MSRV were asked to share important questions they felt were not asked of them by the MHP who conducted their IPV-related screening or assessment. The overall narrative voice attributed IPV etiology to their witnessing relational discord within their respective families-of-origin. Participants, like Leonard, discussed their disappointment that mental health providers failed to inquire about their family history, which they viewed as an important contextual explanation as to why they may have tolerated long-standing intimate partner abuse or used abuse against a partner.

- R: I had mentioned to [my therapist] about my theory about abuse in my family. And I felt like he didn't focus enough on that because I kind of felt like maybe I'm wrong. But I felt like my relationship and my experiences with growing up in my family had a lot to do with me being in abusive relationships. I don't feel like he focused enough on that.
- I: What would have been -
- R: On what made, what caused me to choose.
- I: I see.
- R: He focused more on how to get out of it.
- I: Okay. So that would've been important to you to...?
- R: Yeah.
- I: What was the importance of [discussing abuse in your family]?
- R: Well because that way I could put something tangible, something physical that I could say, well, this is what's causing this. And so maybe I could start rethinking the way I think. (I: Right. Right.) Because this has been embedded in me from childhood. And I wanted him to go back and look into what kind of family life I had and what the relationships were, and what happened and how did that affect me. And, yeah. (Leonard, 57, African American, gay)

Consistent with this etiology, MSR/V who reported regularly using partner violence attributed their abusive behavior to their own experience of childhood abuse, witnessing partner abuse during childhood, and the absence of male role models within the family-of-origin.

- R: [By my therapist] I would have liked to have been asked questions like, first of all, was there any violence in your household when you was growing up.
- I: Okay. So that wasn't really talked about so much at that time?
- R: No.
- I: Why would that have been important for you to talk about?
- R: Because, for me, I would've looked at like she would ask that question that the reason, you know, there was a lot of violence in our household growing up towards me. And eventually, it affected me as I grew up. And it's like every relationship I have been in, it's like one part of me was my mother part. The things she did to her boyfriends, like I said before, that's what I brought into a new relationship, you know, like the controlling, and when I ask you to do something you got to do it. Don't tell me no, everything is supposed to be yes. And when they don't do it then I get drunk or use drugs and pull out knives and sticks and stuff.
- I: What other questions would you have liked to have been asked?

- R: One of the biggest questions, I think, was my father around?
 I: How would that have influenced?
 R: I think if my father was around, I wouldn't have probably turned out the way I am today.
 I: How would you describe that?
 R: I would describe it like if I had a chance to be with my father as I was growing up, he would've taught me some values and morals.
 I: Okay.
 R: I wasn't taught that in our family. We didn't have - our mother didn't display no value or morals, stuff like that. So if you don't have them then you don't know what they are. (Tom, 47, African American, gay)

In contrast to these data from MSR/V, no such data regarding the etiology of IPV emerged from focus group discussions with MHP. While only MSR/V reported beliefs regarding the etiology of IPV, both groups of participants discussed power and control dynamics within a same-gender relationship involving IPV.

For MSR/V, awareness of a *power and control imbalance between intimate partners* did not surface until either close to the end of their relationships, or after these relationships had already ended.

- I: How do you define [IPV] in the context of a relationship involving two men?
 R: Anytime that you have (sighs), anytime that you have an imbalance in kindness and fairness between the two men. And of the men does not know that, one of the men does not know that that's happening, but they just feel really badly about the dynamic in the relationship. (I: Mm-hmm.) And it's hard for me to be more definitive about it that because I'm thinking back on it, and it was just hard to define what I felt at the time and, to a degree, it still is. (Harris, 45, African American, gay)

The potentially threatening nature of dysfunctional power and control dynamics was corroborated by testimonies of MHP. I identified equivocal findings pertaining to MHP beliefs of MSR/V awareness of inter-partner power imbalances in their relationships. On the one hand, some MHP discussed that MSR/V may often be unaware of the disproportionate distribution of power and

control in their relationships. Other MHP discussed that many MSR/V may actually be aware of the partner with which power and control resides. MHP also alluded to power and control dynamics being fluid (as opposed to static), often dictated by a partner's employment or financial status and, therefore, having the potential to vacillate between partners over the course of a relationship.

Lauren, 35: There seems to be an overall impact for one person that is really much more threatening in some kind of way than it is for another person. And I particularly find that more when I'm working with male-identified folks in a relationship with other male-identified folks, more so than with women in relationships with other women. There seems to be a bit more of a push and pull dance about like, oh, well, you're trying to control me that way so I might assert myself in this kind of way. But there's still, generally, ends up being more of a cost to one person than there is to another.

Mel, 57: I would agree with that. And I would also say that sometimes the locus of power shifts in relationships because of some change, someone loses a job and loses income and status, and starts to become dependent on a partner. That dynamic may shift. As a person ages and becomes more vulnerable as a result of that, there may be some changes that result. But overall, usually there is one person who, as Craig put it, finds their world shrinking and one person who is responsible for arranging that.

Aside from discussing imbalances of power and control, participants characterized relationships involving IPV by a notable *course of patterned violence* in their relationships. This phenomenon referred to when discrete incidents of violence first emerged in a relationship, and eventually became continuous, falling into a predictable behavioral model.

I: How would you define domestic violence or intimate partner violence, involving two men?

Lauren, 35: A power and control dynamic that exists either, or can be shown as verbal abuse, emotional abuse, financial abuse or sexual abuse so that one person has more of an upper hand than the other.

I: I see a lot of nodding. Power and control? Power and control is a big component? Okay.

Lauren, 35: I guess it's important to note there's a pattern, that something that happens over and over again. It isn't just a single

time.

I: Now how is this definition, if at all, different from the way we define domestic violence or intimate partner violence among heterosexuals?

Mel, 57: I don't think that there is a difference.

Lauren, 35: No.

When I inquired with MSR/V about the course of violence in their relationship, the overwhelming majority of these individuals stated that violent incidents first occurred within roughly the first two weeks to two years of the relationship. They reported that these incidents went from discrete to more continuous over time, gradually escalating in severity. The time period of initiation varied based on the overall length of the relationship to which they referred. For example a testimony from a participant whose relationship lasted 12 years, shared that he began to notice signs of unfairness as early as two years into a relationship with a partner who would eventually become his live-in partner.

R: Well, I've had physical, primarily physical violence stowed [*sic*] on me, physical violence. In this particular relationship, which I was in for 12 years, it escalated to physical violence. It started off, basically, verbally then sort of escalated a little bit more to a more emotional type of violence. And then in the end, it just became a lot of full-time physical violence.

I: How early in those 12 years would you say that that verbal violence started?

R: The verbal violence started in the first - well, the first two years, after the first two years in the relationship.

I: Then there was some verbal stuff you started [inaudible] -

R: There was a lot of verbal. And then within a short period of time after that, I had experienced a lot of emotional abuse. (Charles, 56, African American, homosexual)

Verbal attacks from partners, partners being caught in lies by participants, and physical abuse were all cited as early instances of violence regardless of the overall relationship length.

Implicit to participants' characterizations of IPV involving a course of patterned violence is the notion that not all violence enacted between partners qualified as IPV. MHP discussed the challenge of distinguishing irregular, discrete incidents of partner violence from continuous, patterned incidents of violence. Several MHP discussed that IPV-related clinical experience was the primary way in which they navigated this challenge.

Angela, 40: Your question was, how did we develop our definition. For me, a lot of it's been sort of like seeing clients over time, and going, oh, yes, this is what this is, and really being clear on what these patterns start to look like. And they start to look pretty similar after a while with different types of abuse. And the responses that people have and the way that they react, and the reasons they present or help all start to seem similar. Not that everybody is the same, but you start to really get a sense that there is something that this is different than somebody in a bar where they got in a fight and they were both drunk. And it wasn't something that ever happened before, and they were upset about other things, you know. It wasn't something that - it's something separate.

Don, 44: It's almost like there are patterns to the pattern. So there's patterns within the relationship (Angela, 40: Right.), and then there's also patterns across the clients.

Angela, 40: Right. Right.

Don, 44: And so trying to like pick apart those similarities potentially.

Angela, 40: Right.

Don, 44: Again, each person is unique, but you start to see some commonalities across folks.

Aside from a course of patterned violence, participants described the *presence of fear* to be a characteristic quality of IPV between partners.

Specifically, participants believed that IPV was characterized by the presence of one partner's fear of the other.

I: Okay. How do you define violence or domestic violence within a relationship involving two men?

R: I would think anything that places you in fear.

I: Okay.

R: You know what I mean? And, of course, that would be on the receptive end. Anything that causes you fear for your safety or your well being. From the perspective of the abuser, causing that fear or that intimidation. (Duncan, 48, European American, gay)

Similar to MSRV, MHP believed that individuals who feared their partners were more likely to be considered regular recipients of partner abuse.

Mel, 57: And I think that the key dynamic, as in any relationship where there's domestic abuse occurring, is fear. One of the results of the behavior, that Lauren just described, is that the person who is being abused is fearful that something will happen or something that they desire won't happen if they don't exceed to the wishes of the person who is using controlling behavior.

Both groups of participants also defined IPV according to the types of violent behaviors that either MSRV or their partners enacted while in male-male IPV relationships. Behaviors participants considered to be IPV fell into at least 12 domains (see Table 1): *physical abuse*, *emotional* (or psychological) *abuse*, *verbal abuse*, *sexual abuse*, *ability- or health-related abuse*, *financial abuse*, *identity abuse*, *abuse involving social isolation*, *abuse of privilege or entitlement*, *abuse enacted through legal means*, *abuse involving children, pets or dependent others*, and *stalking*. Most participants discussed experiencing different forms of violence over the course of their relationship, and sometimes simultaneously. Due to the high volume of definitions and examples provided by participants, I have highlighted below only brief quotes that characterize these forms of abuse. I begin with participants' definitions of physical abuse.

The presence of *physical abuse*, whether or not it was the predominant form of violence used in an intimate partnership, was most often cited when MSRV defined IPV. Physical violence was most often characterized as one

Table 2. Forms of IPV

Form of IPV	Description
Physical Abuse	Hitting, punching, or hurting partner with a weapon
Emotional/Psychological Abuse	Using degrading behavior and language to cause degradation and emotional injury
Verbal Abuse	Aggressive name-calling or threat-making to cause degradation, fear and emotional injury
Sexual Abuse	Infidelity, withholding sex, refusing to practice safer sex, rape, violating pre-established BDSM guidelines
Ability/Health-related Abuse	HIV-related abuse, attempting to thwart one's sobriety, using a mental or physical health condition to control a partner
Financial Abuse	Controlling all money and other financial resources, or refusing to pay for shared expenses
Identity Abuse	Being targeted on account of gender expression and/or sexual orientation identity
Social Isolation	Having social support network limited to partner, or being socially isolated
Abuse of Privilege/Entitlement	Being controlled on account of one's education, age, financial stability, or legal citizenship status
Legal Abuse	Making or threatening to make undue, legally binding accusations toward a partner
Abuse of Dependents	Using pets, children, or dependent family members as a means of controlling an intimate partner
Stalking	Physically or virtually monitoring a partner with or without that partner being aware of being followed

partner hitting, punching, hurting with a weapon or object, or stabbing the other partner.

- I: How do you define violence in a relationship that involves two men?
- R: Okay. Well, the first thing that come to mind when you say violence is actually physical violence -
- I: Okay.
- R: I know there's emotional, verbal, those type of violence. But the first thing that come to mind when I hear the word "violence", I equate something physical, being hit or something of that nature.
- I: What experiences have you had in relationships that you consider to be violent?
- R: Well, I've had physical, primarily physical violence stowed on me, physical violence." (Charles, 56, African American, homosexual)

In addition, MSRVS who reported experiencing violence from their partners often shared that prior to enacting physical violence partners would become rageful and accusatory. Leonard described a situation that characterized this dynamic.

- R: I would define [IPV as] when there might be a partner [who] crosses boundaries. (I: Mm-hmm.) And inflicts physical harm, physical pain, physical harm upon the -
- I: Okay. So it's really a focus on this sort of physical harm. What types of physical harm might those include?
- R: Well, I think of one time when my partner, the big thing he would get jealous. He would think that I'm flirting with other people. And we went out to a theater and there was another couple with us, and he went into a rage and he pulled all his - what do you call that thing when you lock the steering wheel -
- I: Like The Club?
- R: Yeah. We had a car and he attacked me with it.
- I: Really?
- R: And there was a big scene. And someone called the police. We went to the hospital. I went to hospital. I had a fractured arm. And that's an example of what I definitely consider violence. (Leonard, 57, African American, gay)

However, one MSRVS described physical abuse that consisted of a partner refusing to allow physical space or physically limiting the whereabouts of one's partner.

- I: What were some other forms of abuse?
- R: Abuse of my space, my apartment, my home. It was never any physical damage done to it, but it was a matter of not allowing me to have that space. If I did not - if he wanted to come over and, for whatever reason, I said I'm tired or I just don't feel like it today or I have something else to do, that became a reason to either make me feel guilty or to just flat out get angry with me because it wasn't what he wanted. So there was that. And there was also (sighs), there was never, in my case, physical abuse but it was (sighs) the sort of physical abuse where it was, I was never hit or anything like that, but I was sometimes blocked. You know, if I said, "I'm leaving," I would be blocked from leaving and that sort of thing. I was never hit. I was never kicked, flipped, shoved even, but I feel like he didn't respect my physical boundaries by prohibiting me. Even though, eventually, he said he would move. The point is you don't block me, you know. And that's all that comes to mind right in terms of the different kinds. (Harris, 45, African American, gay)

Both groups of participants discussed that the presence of physical violence is often considered an essential criterion of IPV. Thus without the presence of physical violence, IPV was non-existent. Among MSR/V, this limited definition of IPV was expressed most often among those who reported experiencing no physical abuse in their relationships. Participants, like Harris, who experienced non-physical forms of unfair behavior from a partner had difficulty identifying those non-physical forms of violence as indicative of IPV.

- R: ... I just never put it together for myself. And also, there was no physical. I was never beat. I was never hit. So I didn't think of someone saying something cruel to me as being - I really didn't even think of it as abusive behavior. Those words just didn't come to my head. I didn't get any of that until I came to therapy. (Harris, 45, African American, gay)

During their focus group discussions, MHP recognized that MSR/V often have the tendency to equate IPV with physical violence.

- I: You mentioned there's a more general definition people may be familiar with, what would that be?

Don, 44: I think, for me, the go-to is oftentimes physical. I think that people oftentimes equate domestic violence with physical abuse between intimate partners. But the dynamics of power and control impact other arenas besides just the physical abuse.

Aside from the presence of physically violent acts, participants also defined IPV according to what can be classified as emotional or psychological abuse.

Data explicitly referring to emotional or psychological forms of abuse did not emerge from focus group data of MHP. However, MSR/V described how the presence of non-physical abuse affected their “mind” or their “head,” which I identified as euphemisms for one’s emotional and psychological states. In describing such instances, which I categorized as *emotional/psychological abuse*, MSR/V often described the use of hurtful language as a means of degradation and emotional injury.

- R: There’s also a mental abuse.
 I: Can you tell me a little bit about what that might consist of?
 R: Yeah. [Inaudible] telling me that I’m not any good, breaking my self-esteem down. That was a big thing. I think the mental abuse was probably, that happened more than the physical abuse.
 I: Oh, did it?
 R: Yeah. But it took its toll just as deep as if I was being struck.
 (Leonard, 57 African American, gay)

While emotional or psychological abuse was most often verbally delivered from one partner to another, other forms of verbal violence emerged from testimonies of violence shared by MSR/V.

Nearly all MSR/V alluded to ongoing occurrences of *verbal abuse* within their relationships. Unlike instances when emotional or psychological violence was enacted verbally, verbal abuse was characterized as aggressive name-calling,

or threat making. Verbal abuse was either enacted solely by one partner, or enacted by both partners toward each other.

- I: Okay. Now, Tom, how do you define violence within a relationship involving two men?
- R: Well, for me, one, it could be verbally -
- I: Okay.
- R: --and physically.
- I: I see.
- R: You know. And I experienced both.
- I: Yeah.
- R: You know. And the thing was that I put up with it for so long and eventually, at one point, I got tired. I got tired and I started cursing the person out. You know, if you curse at me, I'm going to curse at you. And we got into fights. And one of the things where I was so - I don't know if I should say in love or just infatuated with this person that I felt that I just don't want to let him go. And so I allowed myself to continue to go through that abuse. (Tom, 47, African American, gay)

Similar to Tom's case, when MSR/V reported retaliating with violence against an abusive partner verbal violence was most commonly the mode of retaliation.

Both groups of participants discussed multiple facets of *sexual abuse* within the context of a same-gender male relationship involving IPV. These facets included one or both partners committing infidelities, the withholding of sex from one partner, the refusal to practice safer sex, and violating sexual guidelines related to bondage/dominance/sado-masochism (BDSM). Cody told of the regularly practiced infidelities of his live-in partner, which precipitated his cheating as a form of retaliation.

- I: ... You mentioned sex, how did sex play into that?
- R: Well, he was cheating on me, I guess, I would want sex and then he wouldn't have sex with me.
- I: So what was the way in which you dealt with that?
- R: Mmm, I went out and got sex from somebody else, went out and found other ways to do it.
- I: And how did that, in your opinion, relate to the violence or the

unfairness in the relationship?

R: Because [my partner] would find out and they'd get crazy about it.
(Cody, 33, European American, bisexual)

Craig and Lauren, MHP who both extensively treat adolescents and young adults, discussed how sexually controlling behavior often manifests in the young people with whom they worked.

Craig, 35: I think sex is - especially for young people, I think, who sometimes have a harder time finding out what some of the emotional issues are. It's easier for them to point out sex as an issue of where control happens, and even withholding of sex.

Mel, 57: Mm-hmm.

Lauren, 35: Or [safer sex] barriers.

Other providers described sexual abuse in the context of BDSM. Specifically, they characterized sexual abuse as consisting of instances when safety guidelines or boundaries of BDSM play were either ignored or purposefully violated.

Joanne, 31: I would hope this would be on a heterosexual evaluation, but it probably isn't: sexual negotiation.

Don, 44: Mm-hmm.

Angela, 40: Mm-hmm.

Joanne, 31: And how that's worked out... So if there is any sort of BDSM relationship piece going on, being able to say, okay, well, how do you negotiate who's doing what? Under what circumstances are you allowed to renegotiate? Has it ever happened that you felt a scene got out of control and you weren't able to say anything or do anything about it? And for us being able to step back and not be judgmental, which I think is what people fear when they talk about BDSM relationships. That, oh, well, you're going to think this is domestic violence if I tell you about it, rather than just saying, this is what we do, this is how we negotiate...

Similar to sexual abuse, participants' descriptions of ability- and health-related abuse were multifaceted.

Participants described *ability- and health-related abuse* as including HIV-related abuse, attempts to thwart one's sobriety, and control related to the strategic

use of a mental or physical health condition. Craig described the ways in which HIV-related abuse can manifest in the context of a same-gender relationship involving IPV.

Craig, 35: Something else that comes up as a tool of control is differing HIV status. (Lauren, 35: Mm-hmm.) People can use that as a weapon, sort of threatening to out someone's HIV status. Refusing to use barrier protection, refusing to practice safer sex, those kinds of things.

Tom, one of the few MSRV who disclosed the regular use of violence against multiple partners, offered a backdrop for his abusive behavior toward one recent partner. According to Tom, he became abusive toward his partner when he felt that his partner's regular drug use would threaten his sober well-being.

R: The thing is that he was smoking weed. I was clean and sober. And it's just like I tolerated his bullshit for a very long time. And finally, I believe I hit him first.

I: Yeah.

R: Because he lied. It's like he would tell me he's going over his friend's house. And one day, I followed him. He didn't know I did it. And he went over to this guy's house, and he went upstairs. And apparently they was doing drugs. And when he came out, they went to Walgreen's, and on his way back, I asked him to take off my shoes. And I picked up the shoe and hit him upside the head with it because I kind of felt, why would you do this to me. And I'm taking care of you. I'm there for you. You had nowhere to go, and I'm putting my life and my sobriety in jeopardy to tolerate your bullshit. And so it went on, and I kept giving him chances. There was something about him that I just didn't want to give up on him. I kind of felt that it would get better, but eventually it got worse. And it got worse to the point where he wanted to fight me. One day, he wanted to fight me and eventually I was just fed up. I had started doing drugs, and eventually I tried to kill him. Well, I pulled a knife on him. (Tom, 47, African American, gay)

Craig, in providing another example of ability- and health-related abuse, described how sober-discordance in couples (as well as discordance in age, and

sexual identity development) may leave a newly-sober partner vulnerable to receiving abuse from a partner who may still be actively using substances.

Craig, 35: I think one of the other things that sometimes comes up, particularly with younger people, is that there may be a pattern of a person who is a bit older always dating someone who is newly clean and sober, or always dating someone who is newly out or not out. And again, that's a kind of pattern that can go from one relationship to another that can help to identify the fact that this person is choosing people that he doesn't see as an equal.

In focus group discussions, MHP also described the unfairness that may manifest in a relationship where abusive behavior may be attributed to or excused by the mental or physical health conditions of one partner.

Mel, 57: I was just going to say in those couples where one or both persons has a diagnosed mental illness, a lot of abuse can be blamed on the mental illness and not getting the help that they need for that or maybe the abuse was minimized. They're not on their meds. It's their mental illness. It's not them. Some rationalization going on there.

Aside from the use of mental health-related issues, other MHP described ailments of physical health (real or malingered) being used as tactics of controlling one partner by another.

Don, 44: Hypochondria.

I: Can you talk a little bit more about that?

Don, 44: Really making someone feel guilty about not taking care of you because you're always sick. Insisting that you need attention all the time, or other kinds of really pathological, attention-getting behavior can be a very effective kind of abuse, particularly if there's other kinds of imbalances of power, like someone has been dependent on someone financially. That's another way of making someone feel guilty or responsible about not being a caretaker.

Another form of violence where a discrepancy between partners can be the basis for dysfunction consists of financial or economic abuse.

Most commonly, participants described *financial or economic abuse* as consisting of one partner controlling all money and other financial resources.

- R: He started to control everything.
 I: Okay.
 R: The money. (Albert, 56, African American, gay)

In other cases, participants reported financial and economic abuse consisting of one partner refusing to pay for shared expenses or asking a partner for money.

- I: Can you tell me a little bit about how you define financial abuse?
 R: Mm-hmm. In my case, it was a matter of me constantly being asked to give money and/or material things. Or this sort of hinting that I do those things, you know. Sometimes it was, most of the time, actually, it was not a flat out, "Let me have." It was, you know, "Oooh, I don't have anything to eat." Literally, "I don't have anything to eat," or "I need this money to do it and I just don't have it." That sort of thing. And the reason I call it abuse, in my situation, is because he knew what he was doing. (I: Mm-hmm.) You know, he knew what he was doing. And so often, he could have had more of his own money, but he would spend his money on frivolous things and then come to me for the needs, for his needs. And he knew this was happening. (Harris, 45, African American, gay)

Similar situations were described by participants who, unlike Harris, were either unemployed or were experiencing financial instability during the time of their relationships. Similarly, MHP described various aspects of financial or economic abuse.

- Matt, 32: Just maybe one person is employed, the other one is isn't, and they're saying, "Okay, you only get \$10.00." Or taking, both people are working and one person is holding all the money, and another person has to go and ask that person for money.
 Angela, 40: Or somebody keeps somebody from working.
 Don, 44: Yeah.
 Joanne, 31: Or they have, better yet, lost their job because of the partner (Don, 44: Yeah.) showing up at work or calling at work, or there have been incidents like the night before that kept them from going to work the next day.
 Don, 44: Yeah.

Angela, 40: Or so their financial viability has shrunk.

Matt, 32: I was just going to say in like spending money, too. The folks that - like one person is earning it or they're both earning it, but one is spending it at a disproportionate level, and it's impacting the ability to pay bills, ability to do the things that they were supposed to.

Joanne, 31: Like somebody has to file bankruptcy because of the partner.

Don, 44: I did an intake this week with a guy who hasn't had a job more than two to three months because of his partner always wanting him to quit a job.

Angela, 40: Or you could--there's another thing we haven't mentioned is that when someone refuses to work.

In addition to experiences of financial abuse, MSRV also described incidents of unfairness involving aspects of one partner's identity.

References to *identity-related abuse* most often consisted of one partner being targeted by another on account of his gender expression and/or sexual orientation identity. In all cases of reported identity-related abuse, gender and sexuality were most often intertwined. That is, MSRV discussed instances of identity-related abuse where their partners targeted them for being "too gay" and "not being man enough."

Adding further complexity to identity-related abuse were race/ethnicity-specific norms that placed a taboo on non-traditional (i.e., non-hegemonic) gender identity expression and homosexuality.

R: ...One of the things that was always thrown at me was that I was not masculine. I wasn't, as he would put it, I wasn't a true brother (I: Mm-hmm) because I didn't have his sort of hardness that he identified with masculinity, with Black masculinity.

I: Okay. So to be a Black male, you had to have this?

R: Yes. Yes. Right. To be a real man.

I: Or to be a brother, you had to have this sense of masculinity?

R: Yes, exactly. Yes. So that was thrown at me quite regularly and was also used as a tool to not be sexual. You know, I can't turn on to a guy that's not just really hard and a true brother. (I: Mm-hmm.) So it was used as a sexual weapon, if you will. (I: Right.) And

then, for him, there was the issue of masculinity bringing shame. He felt shameful that he was gay. (I: Okay) That being a Black man and being gay just didn't seem to be able to be in the same room together (chuckles) for him.

I: So there's kind of a mis-fit there? By his definition?

R: By his definition, yes. And I had no problems like that. So it was almost as if that became another weapon to use against. Like, you know, "You have no problem with this so you're a sissy, right?" Naturally, this is him saying, "Naturally, I would have a problem with it because I'm a man." (Chuckles) (Harris, 45, African American, gay)

Like MSRV, MHP also commented on the identity-related abuse that partners often receive, and how partners are targeted on account of both their gender expression and sexual orientation identity.

Lauren, 35: ...The masculinity and emotional abuse around kind of like criticism of masculinity or someone's appearance, all those different kinds of things with just [a] smacking of homophobia.

Craig, 35: Mm-hmm.

Most often, however, MHP discussed how one's degree of disclosure regarding his sexual orientation identity could be used as a mode of control in an abusive male-male relationship.

Matt, 32: I think outness. You know, in terms of like internal comfortability with sexuality and then like the degree of being out within the community or integrated within the community, I think that can have a big impact in the relationships.

Participants of one focus group identified how strain around "outness" can be exacerbated in situations involving family, and during the holiday season.

Lauren, 35: And something that I forgot to mention earlier that often comes up with a lot of my clients is when people in a relationship have different levels of outness. (Craig, 35: Yeah.) That really, truly can become something within relationships that 100% is a very effective tool. You know, when it comes - I'm just thinking of nowadays, or this time of year with like holiday stuff coming, negotiating family stuff, all of this based on someone is out, someone is not out within certain contexts. All these things, it

becomes a very - and going both directions. Like, you know, “I feel horrible. I can’t believe you’re expecting me to go to your family.” That “those people know my uncle.” You know, it can go both ways. It’s not always just about, “I’m out and you’re not.” But those kinds of things.

Craig, 35: That is most definitely true. And I have been seeing here over the last couple months with the holiday season. And it happens every year. I’m just flooded with calls about dealing with a relationship and family during the holidays, and that difference when one person is out and the other person isn’t, and the kind of pressure.

One MHP had an extensive background practicing clinical work with same- and opposite gender couples in relationships involving IPV. He shared his formulation regarding the contribution of misogyny and homophobia to IPV dynamics in opposite- and same-gender couples, respectively. Particularly notable were his thoughts on the role that homophobia played in sustaining identity-related abuse in gay and bisexual men.

Mel, 57: I haven’t had time to really look for it or do a literature search - but I would really like to get a good assessment of a person’s level of internalized homophobia--(Lauren, 35: Oh.)--and heterosexism. Because I increasingly see that as really a crucial part of [abuse] for gay and bisexual men [who abuse their partners] just as misogyny, which is pretty much the same coin, is with straight men.

Lauren, 35: Sure.

Aside from identity-related abuse, participants also described the use of social isolation as a means of partner abuse and control.

Both groups of participants discussed how the social lives of MSRVS often narrowed over the course of the relationship, to eventually only include their partner as the primary source of social support.

I: What are some signs that someone’s life is getting smaller?

Matt, 32: Friends are being limited. You know, you can’t go out with so-and-so.

I categorized such experiences as forms of *social isolating abuse*. Gabe described the contrast he observed between his life before and while being in a same-gender relationship with an abusive partner.

Well, again, it was kind of the manipulation aspect of it. Previously, where I would either go out with friends or co-workers or my family, he stressed the idea of having time with him so that the relationship could be better. So I agreed to an extent. Well, I initially agreed because it made sense to me the more time we spend together, the better our relationship would be. But then I found that I was spending all of my extra time, or any time that I have outside of work, because I wasn't in grad school at that time, was with him and his friends and his family. So it became an issue that, to me, if I wasn't spending time with him I was at work and that was it. It was him and work, and that was all that I had, literally. (Gabe, 32, Latino, gay)

Similar to Gabe, other participants (including MHP) reported cases of social isolation characterizing relationships involving IPV. Like Gabe, MSRV also reported coming to the realization that they were socially isolated during (or immediately following) stressful circumstances. These situations provided MSRV with an opportunity to realize the degree to which family and friends upon whom they normally depended were now absent from their support system. Yet another form of IPV abuse consisted of entitlement abuse.

Entitlement, or privilege abuse surfaced only within discussions between MHP. MHP described this form of abuse as consisting of one's abuse of his partner on account of his being less educated, older/younger, more financially dependent, of an illegal/undocumented citizenship status, or underprivileged in other ways compared to the abusing partner.

Lauren, 35: ... We have had clients come in where there is, something you talked about really briefly earlier, Mel, about older men with younger men. And where the very clear thing is it was probably like four different relationships where there was an older man,

fairly wealthy, with a younger man dependent on him for paying for his education. And there were, in all of these relationships, active moves to reprioritize that you can't continue going to school right now. And then there was sometimes, also, the compounding, "Well, I'm paying for your day-to-day. I'm not necessarily paying for your schooling." So you're taking loans out, but I'm consistently doing things so that you have to withdraw from classes, but you still have all this loan debt, which makes you more and more dependent on me because you have this loan debt. And that's just a pattern that has really come to mind that's just hard to recognize that kind of power dynamic because it can feel so like, "But he's paying all this. Like I have a car. I have a roof over my head. I have all these things." It's true, like you need to stop working right now in order to support his business. I found that to be like, "oooo, that's so...really icky."

Closely related to entitlement or privilege abuse were instances where one partner used the law as a means of controlling his partner.

Legal abuse involved one partner making undue, legally binding accusations toward the other, or threatening to exert such acts. Cases where police were called by MSR/V who were experiencing abuse from their partners occurred while an incident was no longer in progress (i.e., after a partner had fled from the scene). In contrast, cases where police were called by MSR/V who were using abuse against their partners occurred *during* a violent incident. Aside from the involvement of police, legal abuse also included one partner unfairly using a legally binding contract (e.g., lease agreement, order of protection, loan agreement, etc.) to exert unfair power and control over a partner, including threats to commit such acts. The following quote characterizes both aspects of legal abuse that emerged throughout the transcripts—use of legal accusations and use of legally binding documentation. In this situation, Tom, who identified as a

“perpetrator” of IPV, recounts a situation that pre-empted his strangling and stabbing of his 29 year-old partner, Dell.

- R: I believe once I had called the police to get my partner out of my house. Yeah.
- I: And had there been some sort of abuse going on before that?
- R: Yes. Mainly, verbal abuse, physical abuse [inaudible] on my part.
- I: Did you call them because you felt like you might hurt him or that he might hurt you or both?
- R: Well, I called them because I felt like that I may hurt him.
- I: Okay.
- R: Because it got to the point where, once again, I'd done picked up a homeless person off the streets [i.e., Dell], took him in, and eventually, they show their ass. And so therefore, it's like I said - because what made me call the police that night was, actually that was the first time I ever put my hands on Dell. And I think he was, what, 29. And I seen myself really, almost trying to choke him to death, and I had to stop because I'd never been in jail. And I just couldn't see myself sitting in no penitentiary for murder. So -
- I: Now what happened when the police came? Did they know what was going on?
- R: Well, no, we explained. Dell was drunk. He was yelling and cursing. And I was like calm, like I'm talking to you. I was like, “Well, officer, this is the thing. This is my partner. And he showed his ass, and we had a confrontation and stuff.” And I didn't tell them that I pulled a knife on him or choked. I said, “Well he's cursing me out. And he talking about he gonna kill me when I go to sleep. And so therefore, I want him out of the house.” And they were like, “Whose name is on the lease?” I said, “My name is on the lease, and I had them to put his name on lease.”
- ...
- I: Did you feel like the cops were helpful at all in that situation?
- R: They was very helpful because their thing was, “Look, you put his name on the lease so we can't make him leave. Now either you leave and leave him here, or he'll leave and leave you here. Or you'll sleep in the bed, he'll sleep on the floor. But if we come back, both of you guys are going to jail.” (Tom, 47, African American, gay)

The use of legal abuse, as in the case of Tom, should be distinguished from the use of the law to help assuage or protect a person from the effects of partner violence he may be experiencing. For example, a man filing an order of

protection (OP) against a male partner who consistently uses abuse against him would be considered the appropriate use of a legal binding document. Whereas, one partner's filing of an OP against a partner who he is consistently abusing would be considered an undue (and inaccurate), legally binding accusation made with the intent to control. Another way in which IPV was defined involved the use of children, dependent family members, or pets to control a partner.

From these data, only children were reportedly used as a means of controlling an intimate partner. These instances were only shared by MSR/V, and not discussed among MHP.

- R: He started to control everything.
 I: Okay.
 R: The money. Access to me through our friends, or my access to them.
 I: Oh.
 R: Even my access to my kids. (Albert, 56, African American, gay)

Aside from highlighting a narrow yet unequivocal example of dependent-related abuse, this quote also characterizes the simultaneous use of multiple forms of controlling behavior (e.g., financial abuse and social isolation). Stalking was described as one final form of IPV.

Stalking emerged as a means of controlling and “keeping tabs” on a partner's whereabouts. Among MSR/V, stalking was described in the more traditional sense, where one partner would physically follow a partner with or without that partner being aware of being followed.

For instance, in the experience that I'm talking about, this guy had to know where I was every second of the day. And would often show up just to check to make sure I was there. (Albert, 56, African American, gay)

Less traditional stalking behavior surfaced in discussions by MHP. In these discussions, MHP described technology-related stalking behavior, that involving the employment of cellular phone calls, texting, and requiring a partner to regularly correspond with a partner via email or social networking sites.

Craig, 35: Another thing I'm thinking about is just the Internet. I mean (sighs) texting and keeping tabs through texting (Lauren, 35: Technology.) --and Facebook and BGC[live.com], and all of these tools that are so available for people to surveille [*sic*] their partners all the time. And I think it's sort of deteriorated whatever sense of trust people have in each other. The ability to find out where they are, locate where they're at, who they're talking to. Young people are constantly searching other people's phones to figure out who they've been talking to and what they're saying.

Mel, 57: Yeah, I was just going to mention that. I think that probably two-thirds of the clients that I've had in the last couple of years have had some experiences of going through their partner's phones-- (Lauren, 35: Mm-hmm.) --to either find out whether or not they're seeing someone else, or to confirm a suspicion.

Lauren, 35: Mm-hmm.

As highlighted, participants defined same-gender IPV according to a number of dimensions: a social modeling etiology of IPV, power and control imbalances between partners, the presence of a course of patterned violence, one partner's fear of the other, and beliefs about the forms of violent behavior that constitute IPV. The focus of proceeding section will shift, highlighting participants' experiences of initial IPV-related screening. These experiences will be shared through two lenses—from those of MSRVS being screened, and from MHP conducting such screening interviews.

Experiences of Initial IPV Screening

MSRV in Study One described undergoing either IPV-related screenings at some point early in their relationship with a therapist, as either part of an IPV-

related assessment or as a component of a larger battery of bio-psychosocial, initial screening interview. Consistent with these reports, MHP described conducting both screening interviews at initial intakes or conducting informal IPV-related assessments when “red flags” (i.e., imbalances of power and control) were raised during the early stages of a therapeutic relationship. Regardless of the procedure, MSR and MHP discussed three major challenges related to the screening and assessment of IPV in same-gender male relationships. First, were challenges related to discrepancies between client and therapist regarding the *readiness or prioritization of addressing IPV* in treatment. Second, were MSR impressions of *therapist-related factors* including their perceived knowledge regarding same-gender relationships and same-gender IPV. Third, both participant groups discussed the *challenges in identifying aspects of IPV* within the context of a same-gender relationship between two men. I begin by presenting findings of the challenges discussed by MSR and MHP regarding their respective prioritizations to address IPV.

During their respective evaluative experiences concerning IPV, both groups of participants discussed how various discrepancies between the client and therapist presented challenges to addressing IPV-related matters. I categorized these client-therapist discrepancies into two subthemes that included clients’ potential reluctance to discuss IPV-related issues during an initial meeting, and discrepancies in identifying IPV-related matters as a treatment goal. I begin by presenting discrepancies in the “pacing” of client versus therapist in addressing IPV-related issues.

Several MSRV discussed that during their initial IPV-related screening or assessment they were “not feeling ready” to discuss the violence in their relationships. These experiences were shared by MSRV who experienced violence from partners as well as those who used violence against their partners. When they were probed too soon regarding these matters MSRV described several kinds of reactions including, minimizing or denying behaviors they felt were unfair, reporting some behaviors but denying the presence of physical abuse, or a combination of both tactics followed by their refusal to return to therapy. In the forthcoming quote, Gabe describes what he considered a successful therapeutic relationship where he eventually addressed the partner abuse he experienced months earlier. He contrasts his experience with a less successful attempt to seek help in the past.

R: I’m trying to think of my initial meeting and...if she had asked, “Well, what happened?” right away, I don’t think I would have come back. ...I had had counseling experience in the past for [a] total[ly] different, unrelated thing and I didn’t go back. I had two meetings with the person and I didn’t go back... (Gabe, 32, Latino, gay)

MHP, all of whom had specialized in same-gender IPV issues, also described the importance of following the “pace” of a MSRV presenting for treatment.

Craig, 35: Well, I guess my experience has been that my client, people that come to me that want to work on IPV stuff are pretty clear about it from the get-go. And just hearing what Mel was saying and other people were saying, makes me think about, because there are people that come to therapy to work on something totally different than violence in their relationship. And can they still have therapy services for whatever it is that they want to work on without having to delve into unfair relationships? And I think that they can. Usually, there’s a correlation though between what they’re talking about that they see as separate from the violence and what’s going

on in their relationship. And it may take a while to get there. And I think I'm okay with that process happening slowly. Sometimes people don't realize that unfair relationship is part of something that they want to work on until they've covered some other stuff. So when you're asking me what kind of assessment tools I'm looking for to process that or to get at that, I think there isn't a cookie cutter thing for me. It just, I really need to follow the client and when that happens, it happens.

Similar to Craig, other MHP acknowledged that for many MSR/V with whom they had worked, issues related to IPV are not often why they were prompted to seek psychotherapy. When working with such MSR/V, other MHP discussed "pace" in terms of a therapist's mindfulness regarding the language they use to assess partner abuse.

Joanne, 31: People who are not presenting for intimate partner violence services don't tend to react well to terms like domestic violence or abuse or whatever. And so sort of being able to cage the questions that we ask just as like, "This is what normal people go through sometimes. Their relationships are unfair, sometimes things happen. Have these things happen to you?" So it doesn't feel like they are being told that they're in a deviant relationship. And sort of like, then they present some information to you as you're telling me things -- does it fit? Oh, it happens to fit. I have this wealth of information (chuckles) that I can give you. But they have to be in the right frame of mind to get [inaudible] that might not happen on the first contact with somebody.

Support for the successful influence of therapists going at the pace of their clients also emerged from MSR/V data.

R: He was patient. He was patient with me. He wouldn't pressure me. (I: Okay.) He didn't pressure me a lot. He was very empathic as far as if I felt like I was getting uncomfortable, he'd leave it alone. (I: Mm-hmm.) And whatever, like that, without me even saying something. And then eventually, I would come out myself. I don't know I wouldn't say it was chicanery [*sic*]. (Chuckles) But I would come out, I think but it was a set up. (Chuckling) So eventually, it did work. You know what I mean. (I: Yeah.) His patience, you know what I'm saying. His empathy. He was very empathic as far as like - he sort of foresaw a lot of feeling that I

had and he wouldn't really pressure me into – (I: Right. Right.)
 You know what I'm saying?
 (Charles, 56, African American, Homosexual)

The ability of the therapist to be mindful of the client's pace was valuable and eventually disarming of the client. The effectiveness of this strategy was discussed by MSR/V, like Charles, who reported being reticent to disclose IPV-related issues during initial therapy sessions.

The second client-therapist discrepancy in addressing IPV related to goal setting. Specifically, this discrepancy involved reports by MSR/V that MHP did not often recognize or acknowledge the client's immediate needs or goals in seeking psychotherapeutic help.

- R: At the time, okay, I was coming because I wanted help with this issue that I'm in right now. I need help with this. She wanted to explore my past, for instance, the divorce, and not being with the kids, my relationship with my parents—I mean, maybe clearly she was laying some groundwork. I don't know. But after -
- I: It sounds like you had some immediate needs (R: I felt I did.)... that weren't being addressed.
- R: Exactly. So after maybe six or eight total visits, I just quit going...I mean, I felt like 'I need help dealing with this situation right now.'... You know, honestly, I can't say exactly what I was thinking about at the time. 'Help me pave a way out of this.' You know, maybe connecting me to some services where I could get out of this. Help me develop some strategies maybe to get out of this relationship, to shed myself of this relationship. And there just wasn't any talk about the now. I think I came with that kind of an agenda, maybe not knowing, because I'd never really been in therapy before. (Duncan, 48, European American, gay)

My comparative analyses did not yield any complementary findings from MHP related to discrepancies in goal setting. A second major challenge in the screening and assessment of IPV were therapist-related factors.

Therapist-related factors were exclusively reported by MSRV, and according to MSRV these factors presented several notable challenges to IPV-related screening or assessment. One such challenge was MSRV perceptions that therapists of a different gender or sexual identity than the MSRV would be ineffective helpers. Duncan elaborated on a relationship with a previous therapist who he felt had done very little to address the immediate needs he presented while managing the effects of a relationship involving IPV. He contrasted his past experience in therapy with his current therapy experience, the success of which he attributed largely to having a gay male therapist.

- I: How would they have reached you in that session? Let's say you were still pretty firmly in denial and not ready to talk about it.
- R: Well, clearly with her, I can't talk about that because we had that conversation and it never got there. I mean, not in the way I felt my needs were being met. My current therapist and I, the conversation is easy. I don't know that I can answer that question specifically. I know my conversation, my ongoing conversation with my therapist, clearly being with another gay male. My therapist is gay. I think sets, it puts this in a setting, I think, where I can feel like I'm more understood. And the things that gay men go through, two men in a relationship, I mean, just clearly has some dynamics that are indicative to two men. Living together, not even just as roommates. (Duncan, 48, European American, gay)

In another example, Tom discussed how a therapist who did not share his gender or sexuality was automatically deficient in understanding his experience as a gay man.

- I: Did you feel that she understood what it was like for two men to be in an abusive relationship?
- R: I kind of figured she didn't understand that...because she'd never been with a man...You know, and my thing is that if you don't know, then you can't talk about it.
- I: Now if she had been a gay man, asking you those questions, how would that have been different?
- R: I believe [it would have been different] because we really could

relate to each other. Because, one, he would probably share his experience in the beginning, by being in an abusive relationship.
 I: Okay. (Tom, 47, African American, gay)

Also suggested by this quote is the implicit desire on the part of the participant that a therapist and client not only share their gender and sexuality, but also have in common an experience being in a relationship involving IPV. No findings emerged from other participant data related to the shared experience of IPV between client and therapist.

The general perspective that attribute factors such as gender and sexuality were requisites for an effective client-therapist match was reinforced by MSRV experiences where MHP demonstrated a lack of competency regarding gay male culture and a lack of knowledge regarding same-gender IPV. Two characteristic examples are from two different participants. In the first example, Gabe, discussed feeling that he and his therapist shared no common feelings regarding issues relevant to the LGBT community.

I didn't go back because I felt like he, first of all, was not sympathetic to me because I was gay. So I thought even though he was recommended by my physician, who is gay, and he felt that he would be sympathetic to anybody who was in the GLBT community, and I didn't feel that. I didn't get that from the counseling sessions, the two counseling sessions that we were together. First of all, that needs to be a big concern, you know. They need to be sympathetic to those issues that might [be] specific to a GLBT community, specific to anyone whether it is two men, two women. (Gabe, 32, Latino, gay)

In the other characteristic example, a participant describes feeling a relational bond with his therapist despite the therapist demonstrating minimal knowledge regarding how to address IPV in the context of a same-gender relationship.

R: ...The fact is that, basically, her non-verbal communication was very accepting. You know, she would smile. She was very

grandmother. I think she knew that this obviously made people feel comfortable. And in addition to that, she was a very good listener. And she would just say, “Uh-huh. Okay.” Or she would say, “That’s terrible.” You know, so that of course would obviously encourage you to go on because you felt that you were accepted.

I: Absolutely.

R: Plus the fact, too, that she did try to do a great deal of research. Every time I would start a session, she’s like, “Well, I was on the Internet again, and I still can’t find anything,” or “I went to the library, and I still can’t find anything.” And she would say, “I feel kind of at a loss.” And she says, “I hope I’m helping you.” And I said, “No, you are.” I said, “One of the things is, is I seriously thought there was something that I was unconscious of that I was doing that I was attracting or maybe even inviting this.” And so I said, “You’ve reassured me that I’m not.” (Albert, 56, African American, gay)

Notable from this excerpt is the participant’s interest and satisfaction with utilizing psychotherapy to understand the etiology of his involvement with IPV.

In light of his interests, the apparent fumbling on the part of his therapist did little to damage the participant’s view of the therapist’s competency regarding same-gender IPV. However, a therapist like the one characterized in the preceding quote may have been viewed less favorably by MSR/V who presented with a higher degree of IPV-related acuity or distress—someone interested in addressing immediate needs rather than exploring an etiological theory. Seeking help with such a therapist may have left the acute MSR/V feeling like, as Duncan described in a preceding quote, “it never got there.”

Participants also described instances in which therapist-related factors were overcome, and effective client-therapist relationships burgeoned despite MSR/V being concerned about client-therapist match. This most often surfaced when an acknowledgement of sociodemographic difference was pre-empted (in most cases) by the therapist.

- R: What she said to me was, “Obviously, I’m a White woman and you’re a Black man. There may be some things that you say that I’ll have to ask you, well, what does that mean, or how does that come into play here.” And I appreciated that because that was immediately on the table. We never addressed, and it turned out we didn’t need to, we never addressed this thing of, well, I’m a woman and you’re a gay man, I may not understand. That never came up, I guess, because that never, there was no need to talk about that because she always did understand those things. But so because we had that sort of preamble, I was very comfortable at that point with going into more detail.
- I: Did you ever feel that you didn’t want to share any information about your relationship with your therapist?
- R: No. Never. (Harris, 45, African American, gay)

Aside from the notably challenging therapist-related factors presented, participants also described experiencing other challenges within the initial IPV screening or assessment period.

I categorized one final area as challenging to the screening and assessment of IPV in same-gender male relationships. This category included participants’ *challenges in identifying aspects of IPV*, and included both challenges experienced by MSR/V and MHP alike. In offering a general description of this challenge, a member of one focus group stated:

- Matt, 32: I think one thing that I often look for is: one [partner] or the other, is their world shrinking or their environment shrinking? Is one person exerting control over the other person in any area of their life? That’s [what] we...broadly get...when we’re doing assessments...because so many people do have the misconception that it is, you know, just physical—especially, men. And so we just ask, you know: how is your behavior? How has your world been smaller, limited by someone else? I mean, that’s just one that we start off with.
- I: [Do] other folks sort of take that perspective as well?
- Don, 44: Yeah.
- Angela, 40: Mm-hmm.

As suggested by this characteristic datum from a MHP, challenges in identifying aspects of same-gender IPV involved distinguishing the partner who was experiencing versus using partner abuse. However, both groups of participants discussed other challenges that arose during initial screenings or assessments. These challenges included a prevailing heteronormative model of IPV, clients' general knowledge-deficiency regarding IPV matters, clients' reported denial of IPV and, finally, challenges due to characteristics of the pattern and course of IPV.

Harris, like other participants, concluded that the popular media's depiction of IPV was the primary reinforcement source of at least two beliefs regarding IPV— (1) that it occurs exclusively within heterosexual couples, and that (2) men are always the aggressors, while women are always the victims (i.e., IPV is gender asymmetrical).

- R: ... [IPV] orbited around heterosexuality for me mostly.
 I: Can you talk a little bit about that?
 R: Yeah. I mean, my whole life I've seen like, since I was a little kid, I think they started doing this stuff like in the '70s and the Movie of the Week. There would be like these movies about domestic violence and it always involved a man and a woman. And I don't recall any case where the woman was abusing the guy. It was always the other way around. And it was always (sighs) - and it was usually, too, involving white people, you know. I never saw anything like that growing up as an African American. I just never saw it. So none of that came into it for me. (Harris, 45, African American, gay)

This heteronormative bias endorsed by MSR/V, therefore, rendered concepts like “domestic violence” and “intimate partner violence” as inapplicable characterizations of same-gender male relationship dynamics. MHP also

discussed the influence of heteronormative bias in identifying same-gender IPV between males.

Joanne, 31: I think when people hear “domestic violence”, they automatically assume it’s between a man and a woman. And so I suppose, in this respect, and for men and same-gender relationships, for the purposes of the outside world there has to be an element of, ‘yes, this is what we’re talking about’ because their [client’s] immediate reaction will be, “Oh, well, it’s between a husband and wife.”

I: So those [assumptions] are even internalized in the population that you work with?

Don, 44: Oh, yeah. Yeah. Yeah.

Discussions regarding the challenges presented by heteronormative bias were not limited to the experiences of MSR/V; MHP also discussed how their heteronormative biases influenced their abilities to identify same-gender IPV. Matt, a gay male and a licensed clinical social worker, highlighted the presence of heteronormative biases in IPV-related training.

Matt, 32: ... We talked earlier, the difference of pre-training versus post-training. But even in the training, like the statistics that get hammered into you over and over and over again is that males are the ones who perpetrate violence. And that is the case, but not across - and it’s also like the number of folks that report the violence. But even just in terms of the training, I think that that frames how we view what domestic violence is.

These heteronormative biases were a training deficit that Matt and others attributed to why MHP are often less prepared to identify IPV in same-gender relationship than compared to opposite-gender relationships. On a related theme, MHP described that the heteronormative bias of IPV assessment led them to more thoroughly screen for and assess IPV among people in same-gender relationships than compared to people in opposite-gender relationships.

Joanne, 31: I think maybe [IPV in same-gender relationships is] as complicated...as straight DV relationships. It's just nobody looks at straight DV relationships with a critical eye. (Angela, 40: Mm-hmm.) So a woman comes in and says, "I'm being abused." "Yes, your husband is abusing you, case closed." (Two other group members: Yeah.) Rather than, for us, when we're working with same-sex couples, we have to do a lot of examination because there isn't that automatic, "of course you are" - So that's why it feels more complicated because we have to say, "okay, well, what have you been experiencing?", "What has your partner been experiencing?", "What have you all been experiencing together?" rather than just using the fact that you are from a certain gender to make that determination for you.

Like Joanne, MHP implicitly acknowledged the use of "reciprocal" or "mutual" violence between partners in both same- and opposite-gender couples. In relationships characterized with this reciprocal violence, identifying the "victim" versus "perpetrator" of abuse was especially difficult in the context of a same-gender male relationship. Consequently, clinicians working with this population learned to develop a "critical eye" that refrained from relying on a heteronormative heuristic (often based on existing IPV statistics or training). Another challenge to participants' abilities to identify IPV often involved the belief that the presence of IPV was contingent on the presence of physical violence.

Earlier in this chapter I reported the finding that MSRV often considered the presence of physical violence to be an essential criterion of IPV. Consistent with this finding were MSRV reports of initially discussing IPV in a therapeutic setting, and their resulting adjustment to the idea that IPV may consist of non-physical forms of violence.

I: What was it like to first talk about that mental and psychological abuse with a mental health professional for the first time?

- R: It was a little awkward because I wasn't sure that the word "abuse" necessarily applied, but there wasn't another adjective that I could use.
- I: Why weren't you sure about the use of the word "abuse"?
- R: Well, I think traditionally, the word "abuse" is applied to some type of physical harm and something that relates to a physical nature of something taking place. And there hasn't been any physical abuse in my relationship, but I knew that there was something seriously wrong. And I knew that psychological issues and the way one is treated can have just as serious an impact on someone as physical abuse.
- I: Okay. So you knew that even before you sought help?
- R: Yes.
- I: You knew that even though there tends to be this idea that abuse has a connotation of being physical in nature, that your experience was still abusive in some way?
- R: Yes.
- I: But the term "abuse" didn't quite feel like it fit.
- R: Correct. And I'm not sure if it was getting a grasp on what was happening to me, or just the fact that it was the first person [to whom I disclosed]. Conceptually, I was able to realize that one can go through a physical abuse or can go through some type of psychological abuse, but when you insert yourself as the primary person receiving that abuse then it takes on a different feel. (Mitchell, 46, European American, Gay)

Also consistent with findings presented earlier in this chapter, participants discussed how one's implementation of physical abuse was strongly associated with one's self-identification as an "abuser." This association was even present when the client reporting an instance of using physical violence did so in the context of self-defense or retaliation against an abusive partner. In fact, with no reported patterned course of controlling violence, the implementation of violent behavior in these cases was most often motivated by self-defense or in retaliation to ongoing partner abuse they experienced.

Lauren, 35: And then oftentimes, it's like, "Well, I bit my boyfriend. And I bit him so hard that he was bleeding on his thumb." And it's like, "Well, how did you come to be biting him?" And it, you know, "I think I'm an abuser. I think I'm an abuser."

I: What are you looking for when you ask that question?

Lauren, 35: In some ways, looking for what is this person's level of understanding of what it means to identify as an abuser. (I: Okay.) Or as a victim. And so what we often find is the person who calls and says I think I'm abusive, at least like maybe 75% of the time is actually a survivor. That they feel bad about what they've done, and they report it. And they want help. And they want to not do it. "I don't want to bite my boyfriend again." And it's like, "Oh, well, perhaps if he wasn't choking you, you wouldn't have bitten him in order to get his hands off of you." So it's that kind of follow-up questioning about what led up to what happened.

Mel, 57: We have often found that, too, with the few people that do self-refer [to a male partner abuse intervention program]. A substantial portion of them are people who feel badly about something that they've done that was done in response to something that their partner did. We also, I have to say, we find that with the people who are referred to us. There is a certain proportion. And I'd say in the last two years, it's been about 10 to 15 percent, who appeared to us to be more likely to be primary victims of domestic violence.

In addition to the influence of heteronormative biases, MHP also reported that challenges in identifying aspects of same-gender male IPV were related to the general knowledge deficiency regarding what behaviors constituted IPV. This lack of knowledge concerning forms of IPV behavior resulted in a sense of naïveté regarding IPV, which aligned well with attempts by MSRVA to minimize or rationalize abusive behavior.

Craig, 35: I've heard lots of people talk about the struggle, but not necessarily see that their lives are getting smaller due to their partner's behavior. And so that just poses an interesting dynamic just getting them to see how their partner's behavior is affecting their lives. And sometimes it's very difficult for them to see themselves as a survivor or a victim...

Mel, 57: I think that's also true on the other side. It's usually difficult for someone just to reconcile the idea that they are using controlling behavior with their own self-concept. And so they will usually minimize the abusive nature of their behavior. They'll usually rationalize it, reframe it as love or concern or protection.

For example, both groups of participants discussed how the controlling behavior of one partner over another is often “reframed” as jealousy. In the proceeding characteristic quote, Albert discusses some early warning signs of his partner’s controlling behavior, which he initially confused with jealousy.

- I: And he would limit your access to the kids?
 R: Access. I mean, he was just very - and I suppose we’ll talk about this further. In the beginning, he was just very jealous of everything. Very jealous of my relationship with my ex-wife, for whatever reason, my kids, my parents. Just real controlling. Every time I spoke to another guy, he was all over it, angry. (Albert, 56, African American, gay)

MHP also discussed how MSRV, including those who regularly abused their partners, often masked abuse as jealous behavior.

- Mel, 57: I actually also been seeing recently in a few male relationships the overt use of jealousy as way to isolate. Like admitting to the jealousy and saying, “I know I’m jealous, but I just can’t stand the thought of if you are out with someone for longer than 45 minutes.” ...Just had a couple’s intake the other day, [where one partner] literally texted 55 times to the partner that was out.
 I: What are your thoughts, the three of you, on why [jealousy is not recognized to be] a controlling behavior?
 Craig, 35: “If he’s jealous it means he loves me.”
 Lauren, 35: Right.
 Mel, 57: Exactly.
 Craig, 35: “He just wants me and only me.”
 Lauren, 35: Yeah, it’s flattering.
 Mel, 57: That’s right, it’s flattering. It’s a demonstration of love and concern.

According to several MHP, their clients’ lack of knowledge regarding same-gender IPV also contributed to their clients’ apparent denial regarding the severity of their or their partner’s behavior, or the extent to which this behavior was threatening to one or both partners’ personal safety.

- Matt, 32: I think one piece, for me too, is also how much does the person acknowledge that this is a problem. Like are they coming and

saying, “I have anger management problems, I get angry I don’t want to do this.” Versus, are we doing safety planning with somebody who doesn’t see this as being a concern or problem? And I think that, just speaking for myself, that the folks who are willing, acknowledge that it’s something, a behavior that they want to do or do something about, I think that’s easier for me to work versus somebody that I’m trying to do safety planning with who doesn’t see it as something that they want to, that is a problem or a concern. For me, that would definitely be a weakness on my part, how to negotiate some of those things and to come up with some wording to be able to do that.

A portion of MSRV acknowledged how little they were informed about same-gender IPV before first meeting with a MHP. Of these, several discussed the process by which they learned more about IPV in the context of male-male relationships. In all cases, MSRV discussed learning through the use of IPV-related psychoeducational materials provided in-session.

P: When I first started in therapy, I got a lot of written material. (I: Okay.) And I’m a big reader. (I: Mm-hmm.) And so this was stuff that - and I still have it almost two years later – (I: Wow.) --this was stuff that really meant a lot to me because it helped me define further what abuse is, what domestic violence is and how that related to me. I was actually able to look at those things and say, “Oh, yeah, that’s right, that happened to me. Oh, this happened to me.” And then that was all within the walls of [a LGBT health center], you know. And then when I’d go home, I’d look at it in my home. But then when I started to tell other people about it, my friends and my...family.

I: Okay. You told some of your family?

R: Yes. They were all like, “You know, well yeah. Yeah!” They didn’t even - even though I would tell them all through the four years what was going on, they didn’t see it as that. But then when I told them, they were like, “Yeah, right. That’s right.” They were pretty pissed off for me, you know. (Harris, 45, African American, gay)

In Harris’ unique case, the materials he gathered from his individual therapist were shared with others in this life. In sharing this information with others, Harris was able to educate members of his social support system and, in turn, receive

additional validation regarding a situation about which he had previously felt great shame.

Finally, MHP discussed the challenges presented by MSR/V who may not identify their relationships as abusive. According to MHP, MSR/V would often fail to identify their relationship as abuse when they were within a period where an abusive partner was reconciling his recent use of violence (i.e., between violent incidents).

Don, 44: You know, like there's the cycle of violence. So like when clients are coming in the honeymoon phase, like you never know: is this a safe time, is this not a safe time to ask to only meet with the client. Is that in some levels amping up the potential for violence or putting them in an unsafe position because there's this distrust potential that's being created. [Their partner asking] "What are you telling them behind closed doors that you can't tell me?" And then even, clients that I've somehow either witnessed or been involved in some sort of violent act or experience of violence between the two of them, and how do I then know how to interact with the partner at a later point. It's really hard. Very complicated.

Matt, 32: Yeah.

In "dealing with reality," then, MHP must contend with challenges influenced by a cycle of violence.

In discussing their experiences of initial IPV-related screening or assessment, participants discussed several challenges. These challenges pertained to client-therapist discrepancies in the time period considered appropriate to screen for IPV, therapist-related challenges, and challenges in identifying aspects of IPV. The focus of the proceeding section will shift, highlighting participants' recommendations for the effective initial screening of IPV in MSR/V. Similar to the preceding section, these recommendations will be based upon the previous

experiences of MSRV who underwent similar screenings and MHP who have conducted IPV-related screenings of MSRV.

Recommendations for Effective IPV Screening of MSRV

Both groups of participants provided specific recommendations for IPV-related assessment that I categorized into two major areas. These recommendations concerned the *personal and professional attributes of the MHP*, and recommendations for the *format and structure* of the screening procedure. I begin by presenting findings related to participants' recommendations concerning the personal and professional attributes of the MHP.

Recommendations concerning the *personal and professional attributes of a MHP* were exclusively offered by MSRV. In most cases, MSRV stated that MHP be “non-judgmental” and “open-minded” concerning relationships between two men, and same-gender male IPV in particular. MSRV also referred back to their affective experiences during their initial IPV screening, often identifying feelings like fear, anxiety, and vulnerability. Their memories of these feelings influenced the recommendations they highlighted regarding the personal attributes of MHP.

- I: What do you think are some important things to consider [with regard to the therapist]?
- R: Casual. Genuine. Really aware of the risk of coming off as disingenuous. Coming off being too therapeutic. “I’m really sorry about what you’re going through.”
- I: Sort of empty statements?
- R: Exactly. I kind of equate it to that disingenuous waiter or waitress, “Oh, I’m really sorry, sir, but we’re out of that.” Well, you’re not really sorry. So your day will go on regardless. Don’t say that you’re really sorry. Just be real.
- I: ...So anything else about ... good ways to disarm someone in that first meeting, to be able to help understand their experience?

- R: Start in a joking, jovial manner about stuff.
 I: Okay.
 R: Self-deprivation. (Chuckles) For me, and I don't know if that applies to other people, if somebody can joke about themselves, it conveys a certain level of humility -
 I: That makes it easier to relate to them?
 R: Absolutely. Absolutely. Because anybody that's coming is not feeling in the most (pauses) positive manner. And they're not in the most - they're feeling vulnerable. (Gabe, 32, Latino, gay)

While MSR/V provided all recommendations concerning the professional and personal attributes of a MHP, recommendations for the format and structure of the assessment procedure were offered exclusively by MHP. From recommendations concerning the *format and structure* came a general suggestion for an IPV screening tool: an individual, semi-structured interview format replete with opportunity for the psycho-education of the client concerning same-gender IPV. MHP often reported having little time to conduct a biopsychosocial assessment with a new client. While most MHP highlighted the necessity of identifying the presence of IPV among all clients, they underscored that such a procedure be thorough yet brief.

Lauren, 35: So if I'm looking to screen—which, when I talk about screening, it means I'm screening for appropriateness of services or appropriate fit as a client—I do think, like, an individual interview format is the way to go. But that there could [also] possibly be an introduction... some kind of list, type of inventories included with that. I have found it more helpful, when I do have a list... I have found it helpful to actually perform that with someone I'm interviewing though. But that might be because of my curiosity about the information and being able to ask follow-up questions, as opposed to look it over and then ask a follow-up. [That's] because part of what I like to do is to be able to also notice someone's body [and] the way they're answering the question, their pacing. All these different kinds of things, I find, are really important to be able to observe when people are answering these kinds of questions.

Mel, 57: I agree with that.

In addition to being brief yet thorough, participants described an effective screening tool as having a great deal of flexibility. On the one hand, the tool should have the ability to be less structured for MHP who have a great deal of experience working with MSRV. Yet, the tool should also be structured enough to “teach” less experienced MHP how to understand IPV in the context of same-gender relationships.

Joanne, 31: Yeah. I think part of the whole, for me, is teaching. It’s more of a like motivational-type of an interview in a lot of ways because you’re saying, “Hey, you know, sometimes when people have that experience, this happens. Has that ever happened to you?” And if we have all this decision tree stuff, too, that could be limiting in some ways because, for me, a lot of times the conversation just kind of winds around.

Matt, 32: And I see it more as a training tool as opposed to an assessment tool.

Don, 44: Yes. Yeah.

Angela, 40: Uh-huh.

Don, 44: In the same way, like a bio-psycho-social, you can go in and you can have like word for word, ask all these questions or you can have a general idea of categories to hit upon and questions that fall under those so as a way as a training tool. Like what are some of the ways to assess for financial abuse? What are some questions to hit upon -

Joanne, 31: We can’t wait for this to be done.

[Group Chuckling]

Angela, 40: I’m so excited.

Matt, 32: And again, so it could be for folks who are less comfortable with the material, it’s something that you could go down and do it, like a question and answer checklist kind of with a client. But for folks who are more comfortable with the content or practiced it more, you could go in and you could just have a conversation.

Several MHP described structure-related solutions to challenges presented by the need to collect a great deal of information within a brief period of time.

These solutions related to the presence of “skip-patterns.”

Joanne, 31: ...if you were to say like, okay, this client says that he makes all the money. So you ask, “how is the money handled?” And he says he makes all the money. Then you click on that and that would take you to a whole bunch of (chuckles) questions that would say, “okay, you make all the money, does your partner work?” “Who actually is on the bank statements?” I mean, those questions might be useful if they don’t work, too.

Other participants, while acknowledging the value of skip-patterned questioning, acknowledged that its regimented structure ran the risk of compromising the early rapport-building between client and MHP.

Matt, 32: Yeah. I guess my reactions go to that earlier comment about kind of rapport and relationships. I think that there are some kind of key red flags that we could then, would flag further assessment in maybe initial conversation or first couple conversations. But then oftentimes, and I don’t think of this as a fault necessarily or a bad thing, but that sometimes over time some of these conversations come out. And again, like as those things present then you can, again, do further assessment.

The preceding quote also characterizes an implicit acknowledgment by MHP that the “pace” at which MSRVS come to discuss IPV-related issues may be delayed and surface “over time.” It appeared that, regardless of the time in which IPV-related discussion surfaced in a therapeutic setting, MHP identified the value of skip-patterned questioning in being time-sensitive and thorough.

One last structure-related finding regarding the format and structure of the screening protocol related to the order in which MSRVS are asked to report on their use of violence versus that of their partners. Specifically, MHP key informants reported that men who they later determined to be “clearly the perpetrator [of IPV]” (Lauren, 35) would often minimize their violent behavior in comparison to that of their partner as a means of maintaining social desirability. This phenomenon occurred most often when MHP asked IPV-using men about

their partner's use of violence against them (e.g., "Tell me about what violence you've experienced from your partner.") *before* inquiring about their use of violence against their partners (e.g., "Tell me what about what violence you've enacted upon your partner.").

According to MHP, MSR/V who were regular recipients of partner violence also had a tendency to minimize the presence of IPV in their relationship. However, as noted earlier in these findings, MHP reported that regular recipients of partner violence were, ironically, more likely to *over-report* their own use of violence compared to that of their regularly abusive partners. MSR/V did not offer explicit recommendations for screening based on these phenomena. However, the implications of these findings for screening will be discussed again later in this chapter.

Participants provided few explicit recommendations regarding effective IPV-related screening or assessment, which I categorized as related to the *personal and professional attributes of the MHP*, and recommendations for the *format and structure* of the screening procedure. While these explicit recommendations were few, findings that emerged from the early portion of this chapter also provide notable (albeit less explicit) recommendations for the creation of a behavioral screening tool of IPV in MSR/V. Next, I provide a synthesis of Study One's results as they pertain to the development of the preliminary behavioral screening tool developed in this dissertation.

Synthesis of Stage One Results: Implications for a Behavioral Screening Tool

Stage One findings implied that MSRV and MHP alike would benefit from a tool that provided *psychoeducation regarding IPV*. The first educational component perhaps focusing on countering MSRV beliefs that IPV is contingent on the presence of physical abuse. The testimonies of MHP key informants suggested that such a belief could be countered through education about the many forms of abuse that constitute IPV. Other findings suggested that another educational component of this tool could focus on same-gender IPV dynamics. Specifically, this educational aspect of the tool could attempt to counter the heteronormative and gender binaric biases upon which MHP are often trained, and which MSRV have appeared to internalize. For example, this tool could be influential in countering beliefs that same-gender IPV does not exist, and that men cannot be recipients of partner violence.

These findings also implied that MHP and MSRV should be made aware of both partners' use of violence as it occurred throughout the course of their relationship (i.e., not just on discrete occasions). In other words, it appeared necessary to design a tool whereby the awareness of both MSRV and MHP could be raised regarding the *patterned course of power and control* throughout the entire course of an IPV relationship.

Participants also discussed other elements of the IPV screening procedure that significantly influenced the screening of MSRV —particularly, the *establishment of client-therapist trust and rapport*. Findings from these data underscored how effective and accurate IPV screening of MSRV was largely

influenced by the therapist's ability to defuse the defenses of the client, establishing a bond within what was often the initial intake evaluation. Another aspect of establishing client-therapist trust and rapport related to the therapist's use of language. MSR and MHP discussed how therapist's use of terms like "violence" or "abuse" was often ill received by MSR as terms that were either too harsh or non-applicable.

Participants argued that all of these challenges presented potential barriers to the effective screening of IPV. These potential barriers, in turn, influenced the essential properties of the behavioral screening tool developed in Study Two, which was comprised of the final three stages of this dissertation.

Study Two Results

Study two was comprised of three stages (i.e., Stages Two, Three, and Four), the primary aims of which were to create and evaluate the content, format, and structure of the preliminary screening tool based on data from key informants. I outline Study Two results beginning with a description of the preliminary behavioral screening tool created in this study. Following this description is Stage Two: Preliminary Behavioral Screening Tool Construction

The qualitative findings highlighted in preceding subsections of this chapter informed the theoretical elements of the preliminary behavioral screening tool. This screening tool consisted of three components, each of which was informed by findings from Stage One. These components consisted of an interview guide, two decks of cards that represented various violent behaviors that

constitute IPV, and a timeline graphic used to represent the length of a relationship. I begin first by describing the preliminary screening interview guide.

Screening interview guide.

The preliminary screening interview guide was highly structured and assessed 6 general areas of partner-related functioning including terminology one uses when referring to intimate partners, one's current relationship status, one's relationship history, an assessment of IPV in either a current or most recent relationship, an assessment of psychosocial functioning, and a subjective measure of social isolation. Given the safety concerns raised when assessing partner violence within a couples or family session, I designed the tool to be used in the context of a one-on-one meeting. I also developed the tool to be implemented in a battery of assessment tools included within a standard biopsychosocial assessment. This tool is to be administered to all male patients or clients who present with same-gender relationship histories. The tool is designed to optimize administrative time through the use of "skip patterning." With such a design the client's response (i.e., Client: "Yes, I am in a current relationship.") to an initial inquiry regarding a particular topic area (i.e., MHP: "Are you currently in a romantic relationship.") determines the degree to which the client is assessed regarding that topic (MHP: "I would like to ask you some questions about your current relationship.").

The essential properties of the behavioral screening tool consist of three factors: (1) establishing client-therapist trust and rapport, (2) educating the client and MHP regarding IPV, and (3) providing opportunity for a client to become

aware of patterns of control and violence throughout the course of their relationship. I begin with a brief description of how the preliminary screening tool's format and structure was largely influenced by an aim to establish client-therapist trust and rapport.

As outlined earlier in this chapter, barriers to establishing client-therapist trust and rapport involved MHP lacking cultural responsiveness (e.g., appearing to know little about same-gender male relationships), and MHP using terminology and language that MSR/V often felt did not apply to their situation (e.g., “violence” or “abuse”). Findings also highlighted that problems with forming therapeutic alliance arose when MHP probed MSR/V too soon regarding IPV-related violence.

I designed the preliminary screening tool to incorporate qualitative findings related to establishing and maintaining client-therapist trust and rapport. The Preliminary Screening Interview Guide is located in Appendix M. The first major way in which I incorporated Stage One findings into the screener is in the use of language that aimed to be culturally-responsive and to defuse a potentially defensive client. Some examples of these characteristics included the prompting of a potential client regarding terms he uses when referring to a romantic partner (e.g., partner, boyfriend, lover, friend, etc.), including the option for the client to use a first name or a pseudonym when referring to this partner.

The tool was also created to remind clients of the parameters of confidentiality at multiple times throughout the assessment, once at the start of the screener and again when prompted about partner violence in current or past

relationships. Clients are reminded about confidentiality for two primary reasons; first, to minimize any sense of discomfort discussing IPV (as was reported by key informants), and, second, to ensure that clients are aware of the therapist's role as a mandated reporter of suicidal and homicidal ideation.

To minimize the effects of social desirability on the tool's ability to validly screen for IPV, I refrained from using terms like "domestic violence," "abuse" or "violence" when referring to relationships involving IPV. This decision stemmed directly from key informant findings reporting that MSRVS often deny the presence of "violence" either to maintain social desirability, or due to MSRVS lacking awareness of behaviors that constitute partner violence. Instead, when beginning to inquire about the presence of IPV-related abuse in the preliminary screener, I euphemistically referred to violence by inquiring about relationships "in which you could have been happier with yourself or your partner."

Flashcards and "Chart of Unfair Behaviors."

In another aspect of the tool, I developed two sets of flashcards that contained 86 unique violent behaviors (see Appendix N for a listing of these behaviors), one deck (i.e., the white deck) specific to behaviors enacted by the client onto his partner and the other deck (i.e., the gray deck) specific to behaviors enacted onto the client by his partner. I relied on this IPV-related literature to cluster the 86 acts of violence within 11 categories that represented a form of partner violence that key informants shared in Stage One (e.g., "physical," "emotional," "sexual," etc.). Given its significant overlap with aspects of

emotional abuse, verbal abuse was not considered a separate category of violence. Each of the 11 categories of violence comprised a pie chart graphic entitled the “Chart of Unfair Behaviors” (Appendix P). This chart also presented the abbreviations that corresponded to each category of violence (e.g., “P” for physical violence, “E” for emotional violence, “S” for sexual violence, etc.). I used these abbreviations to compose a two to three digit code (i.e., “Behavioral Code”) that I assigned to the bottom right corner of each flashcard. These Behavioral Codes are intended to assist the client in later transferring his selected flashcards onto a graphic timeline (Appendix O; to be explained later in this section).

I developed the flashcards of unfair behaviors in response to key informant data regarding the “clinical” (i.e., negative and impersonal) modality by which behavioral checklist methods assess IPV (see Chapter One). I also developed these flashcards to retain privacy and thereby reduce the effects of IPV-related shame experienced by clients.

When using the flashcards clients are intended to sort through each deck separately, selecting out the cards that describe applicable behaviors. In this portion of the screening clients are able to sort through both decks of flashcards independently, and without having to discuss the contents of these flashcards aloud with the therapist while selecting them. When mapping the occurrence of a particular form of violence on this graphic timeline, the screening interview guide includes directions that instruct the client to simply write down the Behavioral

Code that is unique to the flashcard they selected. The use of these Behavioral Codes is designed to further ensure client privacy.

In addition to retaining privacy, the use of the flashcards is also intended to provide an opportunity to educate the client about the various forms of partner violence that occur within a same-gender male relationship. This educational component of the screening tool is evinced once the client has plotted his Behavioral Codes onto the RelationshipTimeline graphic.

After the client has plotted his selected flashcards on the timeline graphic, the screener then instructs the therapist to present the “Chart of Unfair Behaviors”. This chart is intended to provide the client with an opportunity to identify what forms of violence their selected flashcards fall within. I chose to describe the behaviors as “unfair” (as opposed to “violent” or “abusive”) given key informant suggestions, described earlier, regarding methods of using language to reduce client reluctance or defensiveness.

“Relationship Timeline” graphic.

According to key informants, also essential to effective IPV screening is the ability to recognize the composition of violent behaviors throughout the relationship length, and within a contextualized, interpersonal dynamic.

Attempting to obtain a detailed history of violence as it occurred between partners was especially challenging given the already-noted constraints of retaining client-therapist rapport. To address this challenge I turned to another field in which screening and diagnosis rely on the composition of patterned problem behaviors: addiction.

I chose to adapt Sobell and Sobell's (1992) Timeline Follow-back (TLFB) method to assess the course of violence as it occurred in a same-gender relationship involving two men. As originally designed, TLFB relies upon an individual's personal history to understand patterns of substance abuse or dependence over a diagnostically relevant period of the individual's lifetime (e.g., 6 or 12 months). Aside from assessing substance abuse history, TLFB has also been employed as a method to understanding condom use and non-use in gay/bisexual men (Irwin, Morgenstern, Parsons, Wainberg, & Labouvie, 2006). A few select and memorable events in the individual's life are used as temporal anchors, around which the development of the addiction can be contextualized. It has been reported that for some clients, TLFB provides the first time at which they can visually understand how intrapsychic and external stressors influence their patterns of substance use (Sobell & Sobell, 1992). My intention in incorporating a TLFB methodology into the preliminary IPV screening tool was to provide MSR and MHP with the opportunity to visually identify patterns of violence between partners as they occurred over the course of the relationship.

The TLFB approach was incorporated into a graphic tool I designed and entitled the Relationship Timeline (Appendix O). The Relationship Timeline was comprised of two sides, with one side pertaining to the current relationship in which a client "could have been happier" and the other side pertaining to the most recent relationship in which a client "could have been happier" ("Current Relationship" and "Most Recent Relationship," respectively). Clients complete only one side of the Relationship Timeline, deferring to a current relationship or

(if they are not currently in a relationship involving violence) the most recent relationship involving violence. With exception to their titles, the two Relationship Timelines are identical.

Each of these Relationship Timeline templates is a landscaped sheet, containing a horizontal, unidirectional arrow dividing the page. The top of the horizontal arrow is a white space that contains the word “You.” Below the horizontal arrow is a gray space containing an extended underscore mark (i.e., “_____”) with either “Current Partner Name” or “Most Recent Partner Name” inscribed below it. Onto this underscore mark the therapist writes the name of the client’s current or most recent partner. I used gray scale in developing this graphic given the relative ease with which gray scale retains appropriate tone when photocopied. Several spaces requiring dates are also enlisted on the Timeline. These dates pertain to the relationship start date, end date (if applicable), and the current date.

In borrowing from TLFB, the screener first asks for three temporal anchors, or “Defining Moments,” that occurred throughout the extent of the relationship. Instructive scripting asks the client to share Defining Moments that are both positive and negative, and presented a memorable or “pivotal” period in the relationship. The therapist is instructed to record, in the screener, these Defining Moments and the approximate date in which these events occurred. The therapist is then instructed to abbreviate these defining moments into short phrases, and the therapist ascribes these short phrases onto areas of the timeline that correspond to the dates in which the events occurred.

After the three Defining Moments have been recorded on the timeline by the therapist, the therapist requests that the client record all the selected flashcards onto the timeline. Recording these flashcards on the timeline, referred to as “plotting” in the instructions, involves the client inscribing their Behavioral to a discrete section of the timeline that corresponds to the time period in which the selected behavior/s occurred. While the Behavioral Codes are identical on both the white and gray flashcards, their placement on either the top or bottom halves of the timeline are what distinguish the codes from each other once they are mapped on the timeline graphic (e.g., white half equals violence enacted onto the partner, gray half equals violence enacted onto client by his partner). The therapist instructs the client to begin from the most recent time period at which a violent act occurred, mapping behaviors backwards in time until all the selected cards have been mapped onto the timeline.

The client’s selection of flashcards begins with his selecting applicable cards from the white deck, which represent violent behaviors he has enacted unto his partner. The client then selects flashcards from the gray deck, which represent ways in which the client’s intimate partner used violence against him. Similarly, when plotting Behavioral Codes on the Relationship Timeline, clients are instructed to first plot the codes that pertain to their use of violence against an intimate partner, followed by the plotting codes pertaining to their partner’s use of violence toward them. The order by which client’s selected white, then, gray flashcards and plotted the corresponding Behavioral Codes of these flashcards onto the timeline was based on MHP findings from Stage One. According to these

findings, MSRV who are regular partner abusers are more likely to accurately report the extent to which they use IPV when questioned about their versus their partner's use of violence.

The screening interview guide, the flashcards and chart of unfair behaviors and the Relationship Timeline graphic are elements of the behavioral screening tool that were developed directly from MSRV and MHP data collected and analyzed in Stage One of this study. These four major elements were designed to address three major problem areas that emerged from Stage One findings as barriers to the effective screening of IPV in MSRV: a lack of awareness regarding same-gender IPV, its patterned course of violence, and client-therapist trust and rapport-building. The subsequent section of this chapter will highlight the feedback provided by participants in Stage Three of this study, where I piloted the tool by administering it to key informants via feedback interviews (with MSRV) and focus groups (with MHP).

Stage Three: Key Informant Feedback on Preliminary Screening Tool

Compared to data I collected in Stage One of this study, the data I collected in Stage Three are different in two major ways. First, given that the aim of Stage Three was to collect feedback regarding the preliminary screener (as opposed to explore the phenomenon of same-gender IPV), the findings from Stage Three are brief and non-phenomenological by nature. Key informants simply reported what portions of the screener they found as effective or ineffective in the screening of IPV. In addition, data from Stage One consisted of transcribed focus group and interview data. However, data from this stage not

only consisted of transcribed interview and focus group data, but also consisted of notes and hand-written revisions key informants made directly onto drafts of screening materials, and key informants' notes made on scratch paper during interviews or focus groups.

Given the rather straightforward and uncomplicated nature of Stage Three feedback data, the presentation of these findings is brief and does not include transcriptions of lengthy narratives or characteristic quotes to illustrate the findings. These findings are arranged according to the aim of this stage. The feedback outlined in this subsection of the chapter includes elements of the preliminary screener that key informants appreciated, as well as their suggested revisions. These findings begin by outlining the feedback key informants provided regarding the content of the preliminary screening tool.

Feedback regarding content.

The feedback key informants provided regarding the content of the screening tool related to the elements of the tool where language and themes were more prominent. These areas included the screening interview guide, the flashcards, the chart of unfair behaviors, and the Relationship Timeline.

With respect to the screening interview guide both groups of key informants appreciated the way in which it was inclusive of diverse sexual orientation identity with references to "partner," "boyfriend," and "lover." Both groups of key informants also felt that the instructions were clear; however, the majority of them suggested that the wording of item two be improved to be made less confusing ("Have you ever been in a relationship in which you could've been

happier either with yourself or with your partner?”). MHP highlighted how the clarity of this item was essential to the effectiveness of the tool given its role as the primary item upon which subsequent IPV-related questions are based.

The content of the flashcards was most often commented on by MSRV, who reported that the language of the cards was easy to comprehend. MSRV who only participated in Stage Three (i.e., men with no prior history of mental health care related to IPV) provided the greatest amount of praise for the flashcard’s content. From these key informants emerged comments and notes stating that while challenging to read due to being so “up front” regarding violent acts, there was “truth in the cards.” One MSRV in Stage Three reflected on a client’s potential thought process while completing the flashcard activity, “Wow. This happened to me and it’s on a card. Should I talk to the therapist about it?”

However, MSRV (including several MSRV who praised the flashcard activity) also acknowledged how feelings of IPV-related guilt or shame and concerns related to confidentiality could lead some clients to be reluctant to share. According to MSRV, the reluctance of some MSRV to share their experiences of IPV would persist even despite the privacy afforded by the flashcards. To address this reticence, MSRV and MHP suggested that language pertaining to the parameters of confidentiality be added to the beginning of the flashcard activity.

While both groups of key informants provided praise for the vast and accurate amount of behaviors enlisted on the flashcards, they also suggested that two additional categories of cards be added. They suggested that one of these categories should be related to substance use behaviors that influence the power

and control dynamics in a relationship. One MSRV provided an example of such content based on his personal experience, “I forced him to use drugs because I was using.” The other category both key informants suggested be included in the decks of flashcards were “blank” cards that allowed the client to state an act of violence that he may not have seen reflected in the prefabricated deck.

Additional feedback on the screener’s content related to the Chart of Unfair Behaviors and the Relationship Timeline. The content of the Chart of Unfair Behaviors, with its listing of the various forms of violence included with corresponding Behavioral Codes, was praised as “helping tie all the content together.” While the content of the Relationship Timeline was also praised for being brief and easy to visually comprehend, several MSRV commented on how difficult it was to remember the specific meanings of the Behavioral Codes they mapped onto their respective timelines. They suggested having a list available upon which clients can reflect. These findings continue by outlining the feedback key informants provided regarding the format of the screening tool.

Feedback regarding format.

When prompted to provide feedback regarding the format of the screener I asked key informants to consider the “mode” or the “way we went about talking about this subject.” Feedback regarding the tool’s format thematically related to the interview guide, the flashcards, the Relationship Timeline, and the interpersonal dynamic. In general, MSRV with histories of seeking IPV-related help appreciated the one-on-one format as opposed to individually completing a

checklist of violent behaviors, which they reported as having felt “too clinical” in the past.

The screener ran an average of just over 33 minutes when administered in the two focus group meetings that occurred in Stage Three. MHP in both groups expressed concern that the screener was too time-consuming and potentially redundant. The most commonly suggested solution was that the psychosocial aspect of the screener as well as the social isolation portion be omitted. The rationale for this suggested omission was based on the premise that the tool cannot be expected to “be all things to all people.” That is, MHP felt that the tool should focus on screening for same-gender IPV, and be brief enough to rely on other tools administered within an initial intake evaluation to more thoroughly assess psychological and social functioning. No other suggested revisions were made related to the format of the screener.

Additional feedback related to the screener’s format included praise by MSRV for the flashcards activity’s ability to optimize the patient’s privacy. One MSRV, who participated only in Stage Three, stated that this privacy “made it easier for me not to lie.” Also included in the positive feedback regarding the flashcards were comments by MSRV that the activity allowed them “time to reflect on my own” or “hold” the cards individually and reflect. According to MHP of all experience levels, the flashcards were praised as a way to remove a client’s potential concern regarding judgment, while also retaining “objectivity in questioning” about behaviors that may constitute IPV.

Aside from providing praise for the flashcards, Key Informants also appreciated the inclusion of the Relationship Timeline activity. MSRV most often relayed an “eye opening” moment they experienced after plotting their flashcards onto their respective timeline. Several MSRV reported having greater awareness about their or their partner’s repetitive uses of certain forms of violence and, in some cases, how these forms of violence transformed over time (e.g., “I can see how it went from emotional [violence] to physical [violence].” MSRV also praised the way in which the flashcard and timeline exercises provided an opportunity for MSRV (particular those who were regularly abused by a partner) to become aware of early patterns of violence of which they were otherwise previously unaware. For example, one MSRV discussed how prior to completing the screener, he had not considered early forms of emotional unfairness to be forms of violence. Next, I outline the feedback key informants provided regarding the structure of the preliminary screening tool.

Feedback regarding structure.

Included in my prompting of key informants’ feedback regarding the screening tool’s structure were phrases like the “flow” or “ordering of” the content areas or items in the screening tool. Again, emergent feedback related to the tool’s interview guide, the flashcard activity, as well as the Relationship Timeline. Overall, the structure of the tool was praised as relatively efficient. One MSRV commented that the screener used “few tools to get to a big problem.”

MSRV also reported an appreciation for the structure managing to “ease into” questioning regarding violence, while managing to be “direct” about the

occurrence of these behaviors. With respect to this aspect of the structure one MSRV noted, “I felt comfortable.”

In contrast, however, MHP expressed concern regarding the direct questioning within the interview guide. According to data from a focus group of MHP who specialized in working with MSRV, concern arose regarding how the structure of questioning in combination with the one-on-one format would resemble a power imbalance between therapist and client. According to one MHP, this structured questioning could “feel a bit like the power-and-control dynamic some victims [of IPV] might already feel.” Other feedback on the interview guide was that its skip patterning, while beneficial, should be made easier to visually follow.

One major criticism of the interview guide’s structure related to item two (“Have you ever been in an intimate relationship in which you could have been happier with yourself or with your intimate partner?”), which was the item primarily responsible in determining a client’s eligibility for being administered the entire screening protocol. All MHP felt that including the item as worded in the final screener would engender too high a volume of affirmative responses from clients. Some MHP left comments on their drafts of the screening interview highlighting concern that the item was not specific enough – “sounds too existential” and “who *can’t* answer ‘No.’” That is, MHP were concerned that retaining this item would increase the likelihood that MHP would administer the entire screener to men with no previous history of IPV-exposure.

MHP provided constructive feedback regarding the layout of the screening interview, which they commonly described as “dense” and “hard to follow.” Suggested revisions involved re-numbering the items to flow more easily, and creating a greater amount of space between each item.

Other feedback related to the screener praised the ordering of the flashcard administration; specifically, requiring MSR/V to first provide their use of violence followed by their partner’s use of violence. One MSR/V with no history of IPV-related screening or psychotherapy appreciated this ordering “because it showed how little I did in comparison [to my partner].” Other MSR/V who reported using partner violence regularly shared other positive feedback regarding the ordering of the flashcard selection, including “[it] gave me an understanding of the onus I had [*sic*],” and “[they allowed me to] own up to what I did.”

Additional feedback related to the screener’s structure was made by MSR/V, and related to instructions and operations of the screener. For example, several comments were made that prior to administering the flashcard portion of the screener, an overview of the activity’s purpose should be provided. With respect to the Relationship Timeline, the only structural feedback was that the timeline itself should be longer and wider, allowing additional space in which clients can write. Last, I outline findings related to additional feedback provided by key informants in Stage Three.

Additional feedback.

The additional feedback provided by key informants regarding the screening tool related to the Timeline Activity, and feedback regarding the

potential utility of the screener outside of initial assessment milieus. With respect to the Relationship Timeline Activity, all key informants suggested that items be added that elicit reflection from clients following the completion of the Relationship Timeline. Key informants suggested that items include, “What are your thoughts and feelings after looking at this timeline?” “How would this timeline compare to other the other relationships [that involved violence] you mentioned?” MSRVP emphasized that reflective questions be asked after each portion of the timeline was completed “to help him [i.e., a client] really think about this stuff.”

MHP, specifically those who had little experience working either with IPV or with same-gender couples, stated that the tool had utility beyond an initial screening. One MHP wrote in her notes “Can screener go into phases? Prescreener and therapeutic tool?”, suggesting that the tool could be employed as a screener and as a psychotherapeutic tool. Other MHP supported this idea, discussing the tool’s utility as a screener and “eye-opening” potential when employed in the context of an ongoing therapeutic relationship.

Overall, the majority of feedback from key informants pertained to the content, format, and structure of the preliminary screening tool. Most commonly, key informants provided feedback related to the interview guide, the flashcard activity, and the Relationship Timeline exercise. Additional feedback provided by MHP related to the tool’s potential utility in therapeutic settings as well as initial evaluation settings. The valuable feedback provided in Stage Three informed Stage Four, which consisted of my final revision of the behavioral screening tool.

Stage Four: The Finalized Behavioral Screening Tool

The final stage of this study consisted of my refining the preliminary behavioral screening tool based on the feedback highlighted in the preceding subsection of this chapter. The finalized version of the screening tool is entitled the *Fairness And Relationship Equality (FARE) Screener*.

My choice of name for the screening tool was based on two reasons. First, I chose to create an acronym for the name of the screening tool so that providers who use the tool could reference it easily. Second, I chose to situate the name of the screening tool within a framework of relationship fairness and partner equality because such an approach rather innocuously refers to abuses of power and control without making explicit references to intimate partner violence, partner abuse, or domestic violence. Findings from Stage One highlighted how the employment of such terms were negatively received by MSR/V and often resulted in barriers to their effective screening.

Similar to the preliminary screening tool, the FARE Screener consists of an interview screening guide, a Relationship Timeline graphic, and the two decks of flashcards. Consistent with key informant feedback, the flashcards now include behaviors related to alcohol and drug abuse (e.g., “You forced him to drink/use drugs against his will” or “He forced you to drink/use drugs against your will,” etc.). Subsequently, the Chart of Unfair Behaviors now also includes “Alcohol and Drugs” as the twelfth category of unfairness.

MSR/V provided feedback related to the small amount of space on which they could plot their Behavioral Codes. I chose not to revise the graphic so that it

can be printed on a larger sheet of paper (e.g., legal sized paper) because the limited resources of some MHP to print out such a document may render it infeasible. Instead, I made several minor formatting changes to the 8.5” by 11” graphic, and increased the writing space by approximately two squared inches. I also made minor changes that resulted in the timeline being reduced to one side of a sheet. This change will decrease the amount of paper needed to administer the Relationship Timeline activity.

The Interview Screening Guide of the FARE Screening also underwent some revisions based on data gathered in Stage Three. The FARE Screener consists of three major content areas that gather quantitative and qualitative data concerning one’s (1) relationship history, (2) history of relationship unfairness, and (3) assessment of safety. Overall, the FARE Screener strongly resembles the preliminary screening tool in terms of content areas. However, one major revision consisted of the removal of content areas pertaining to psychosocial well being and social isolation. These areas were removed based on recommendations that these areas of functioning could be better assessed using pre-existing measures that are commonly employed during a bio-psychosocial intake assessment, and considered reliable when administered to MSRV.

The administration of the FARE Screener is largely dependent on the reading level of the MHP who administers it. In most cases, with the exception of MHP who may not have advanced degrees or post-secondary training (i.e., paraprofessionals or community liaisons), MHP are unlikely to demonstrate difficulty administering the screener. Two portions of the screener that require

MSRV to read are the flashcards, the instructions of the Relationship Timeline activity, and the categories enlisted in the Chart of Unfair Behaviors. MSRV who are illiterate, do not read English, or who have low levels of reading ability, may find it difficult to complete these portions of the FARE Screener. I suggest that MHP inquire about the reading level of each MSRV, and whenever deemed appropriate, read content of these elements aloud to the client. It is important to note that while helpful for a client who is not able to read, the reading of content will comprise the brevity of the screening process as well as the private manner in which MSRV would otherwise interact with each flashcard he chooses.

A complete version of the FARE Screener is attached as Appendix Q. In addition, the content not previously included in the preliminary flashcards are attached as Appendix R.

CHAPTER IV

DISCUSSION

The purpose of this study was to determine the essential components of a behavioral tool intended to screen for the occurrence of intimate partner violence (IPV) in same-gender relationships involving men. In the first stage of this study, I gathered qualitative data regarding the behavioral screening of same-gender IPV from two groups of key informants –men in same-gender relationships involving violence (MSRV) and community mental health providers (MHP) with varying degrees of clinical experience with this population. In Stage Two, I developed a preliminary screening tool based on these data. In the study's third and fourth stages, I piloted the preliminary screening tool with both groups of key informants, and refined the instrument based on feedback MSRV and MHP shared during interviews and focus groups, respectively.

This chapter is organized to expand upon the preceding chapter of results and pre-discussion so that, wherever possible, links are drawn between the study's findings and previous research cited in Chapter I. The current chapter begins by discussing emergent findings from all stages of the study. Next, the implications of these themes for clinical practice and community-level change are highlighted. Following a discussion of the study's implications is a discussion of the study's strengths and limitations. This chapter concludes with directions for future research on IPV in lesbian/gay/bisexual and transgender (LGBT) populations.

Commentary on Study Results

Phenomenological findings from Stage One of this study had significant implications for the design of the IPV-related behavioral screening tool developed in the study's second, third and fourth stages. These implications were directly related to the research questions that guided my inquiry in Stage One. My research questions pertained to how MHP and MSRV define the parameters of IPV in the context of same-gender relationships. My research questions also guided my investigation of the extent to which same-gender male IPV fits and does not fit within traditional conceptualizations of IPV (i.e., those informed by family violence and traditional feminist theory). Last, the research questions of Stage One guided my exploration of additional factors that contribute to IPV within the context of a same-gender male relationship.

My first two research questions related to the ways in which MSRV and MHP define IPV. As outlined in Chapter Three, MSRV and MHP defined IPV according to several domains that were largely consistent with previous literature—an etiology of IPV rooted in social modeling theory, a presence of power and control imbalances, the presence of pattern instances of violence, and the presence of partner's fear of the other (AVP, 2003; Burke & Follingstad, 1999; Johnson, 2003; Merrill & Wolfe, 2000). As expected, however, several violent acts that could be considered more unique to same-gender male couples emerged. These behaviors included forms of identity-related abuse and HIV-related abuse (AVP, 2003; Greenwood et al., 2002).

Findings from Chapter Three also highlighted how heterosexist biases were internalized by MSR/V and also reinforced by MHP who assumed a “prototypical” approach. In this Chapter I will discuss how these biases underscored the ways in which partnership dynamics between same-gender male partners did not fit within the traditional conceptualization of IPV—a focus of my third research question.

My final Stage One research question pertained to the ways in which MHP and MSR/V understand the contextual factors that may be indicative of (or exacerbating) IPV. In this commentary, I will highlight the challenges that key informants encountered when attempting to understand the partner abuse within the context of a same-gender male relationship involving violence.

Guided by my research questions, the findings from Stage One outlined three problem areas where MHP and MSR/V alike often (1) lacked knowledge pertaining to IPV in same-gender relationships, (2) lacked awareness regarding the patterned course of violence in a same-gender relationships involving IPV, and (3) reported inaccurate behavioral screening due to issues related to client-therapist rapport.

These three problem areas informed the specific elements of the preliminary behavioral screening tool, on which Stage Three key informants provided feedback. At the start of this chapter, I discuss the potential sources of these three problem areas, how I addressed them through elements of the behavioral screening tool, and how key informants received these elements of the

tool. I begin by discussing how heteronormative biases influenced the IPV-related knowledge both groups of key informants demonstrated.

Heteronormative Bias in Screening Same-gender IPV

Stage One participants described challenges to understanding IPV within the context of a relationship between two men. Specifically, biases rooted in heteronormativity appeared to influence both MHP and MSRVA abilities to view IPV outside of a heterosexual context, and to view men as “victims” of partner abuse. Heteronormativity refers to a belief that heterosexuality is the societal norm (Herek & Garnets, 2007). According to a heteronormative framework, relationships are considered deviant when they are not between two heterosexuals who are of opposite gender identities and opposite biological sexes. Michael Warner (1999) has identified the predominance of heteronormativity in Western culture, while others (e.g., Harper & Schneider, 2003) have associated heteronormativity as both a byproduct and reinforcer of social oppression upon LGBT communities. Heteronormative bias among MHP conducting same-gender IPV assessments has already been identified (see Blasko et al., 2007 in Chapter One), as has internalized heteronormative biases in members of oppressed LGBT groups, including gay men (Herek & Garnets, 2007).

As characterized in Chapter III, MSRVA and MHP endorsed beliefs that all individuals (irrespective of sexual orientation identity) were subjected to heteronormative biases. According to these biases, two beliefs regarding IPV most often emerged — (1) that IPV occurs exclusively within heterosexual

couples, and that (2) men are always the aggressors while women are always the victims of partner abuse (i.e., IPV is gender asymmetrical).

The screening tool attempts to counter the influence of these heteronormative beliefs in two ways. The first way it counters these heteronormative beliefs is by having clinical utility in screening partners who may regularly use violence as well as those who may regularly receive it. This approach is in contrast to that of other measures, which focus on solely capturing either the experiences of the “victim” (who is usually assumed to be female) (i.e., Marshall, 1992) or the “perpetrator” (i.e., Rodenburg & Fantuzzo, 1993)(who is assumed to be male) of partner abuse. Such measures are rendered obsolete when attempting to categorize a male victim of same-gender partner violence.

The second way this screening tool attempts to counter previously highlighted heteronormative beliefs is by relying on the completion of the Relationship Timeline to provide a narrative and context of the presence, course, and pattern of violence. This is in contrast with methods that Ristock (2002) critiqued, where MHP with little contextual information regarding violent behaviors must rely on heteronormative heuristics to reach a screening recommendation. Ristock (2002) highlighted how these heuristics may include the client’s gender identity or expression (i.e., “butch/masculine” = perpetrator), or a reliance considering the partner who initiated violence to be the “abuser.”

The internalization of heteronormative biases by MSRV hindered the effectiveness of IPV screening with this population. Additional analysis of both MHP and MSRV Stage One data highlighted how MSRV who were regularly

abused failed to identify as victimized. Ironically, participants reported that a MSRV who used occasional physical violence in self-defense or retaliation most often identified himself as the “abusive partner.”

It may at first appear counterintuitive for a MSRV to so readily identify as an “abuser” after only periodically using retaliatory physical violence toward a partner who was regularly abusive. However, qualitative findings regarding heteronormative biases may explain this otherwise contradictory phenomenon. Stage One findings from both groups of participants often highlighted how heteronormative messages were internalized by MSRV. For example, MSRV disclosed beliefs that IPV was a primarily heterosexual phenomenon with gender binaric roles, where males fit the profile of “perpetrator” and females “victim.” Unaccounted for within this heterosexist and gender asymmetrical paradigm were MSRV who experienced regular abuse from male partners, especially those who also reported using occasional retaliatory physical violence. Subsequently, even among MSRV who reported using physical violence only in retaliation or self-defense, the label “abuser” was consistent with heteronormative social constructions and, therefore, more readily apprehensible.

Moreover, MSRV beliefs that IPV was contingent on the presence of physical violence may have also explained their tendency to gravitate toward identifying as “abusers” (i.e., “I must be an abuser because I am male and I used physical violence against my partner.”). This phenomenon of misnomers most certainly presented challenges to both MSRV and MHP identifying IPV.

To address this particular problem area, I created and refined elements of the screener to provide psychoeducation regarding IPV. Specifically, the flashcards and Chart of Unfair Behaviors were designed to provide education regarding the various behaviors and forms of violence that constitute IPV, thereby countering MSR/V beliefs that IPV is contingent on the presence of physical abuse. Feedback data related to the flashcards highlighted key informants' appreciation for the broad variety of behaviors reflected in these cards. The violent behaviors included in these cards were numerous, and all informed from the narratives of Stage One participants as well as the literature cited in Chapter I.

The inclusion of flashcards, the inclusion of substance abuse related behaviors that co-occur with IPV, and the inclusion of a Relationship Timeline accounting for both partner's use of violence is unique to this screening tool. That is, no other known IPV-related behavioral screening tool, including those recommended by the Centers for Disease Control and Prevention (CDC, 2006), attempts to capture as large of a picture of violence across both partners, and through such a non-traditional method. Next, I describe how challenges to the effective screening of IPV were due to MHP difficulty contextualizing patterns of violence in same-gender relationships.

Inadequate Contextual Understanding of Violent Behavior

Commonly highlighted by MHP and MSR/V was their difficulty determining a necessary diagnostic criterion of IPV: the presence of a pattern of abusive behavior. For example, MSR/V who experienced partner abuse discussed a failure to identify the power imbalances and unfairness they experienced as

indicative of abuse. As a result, they often failed to recognize the escalating severity of the abuse until they reached a point of distress, which most often prompted their pursuit of psychotherapy. In some cases a recognition of the course and severity of the abuse did not occur until the violence in their relationships had escalated and become physically abusive, or not until they retrospectively reflected on a previous relationship while in psychotherapy. The degree to which participants struggled with identifying a power imbalance within their relationships may have been due to the insidious nature by which partner violence has been noted to develop (Walker, 1979).

However, findings from MSR/V were not alone in indicating a difficulty with identifying imbalances of power, control, and unfairness in IPV relationships between two men; MHP also highlighted a similar difficulty. However, MHP attributed their difficulty with identifying IPV to the apparent under-reporting of partner violence by some MSR/V. This under-reporting was noted to surface from both men who used partner abuse and men who experienced partner abuse. Consistent with findings noted in the preceding discussion point regarding education, some MHP reported that MSR/V might underreport violence due to a lack of knowledge regarding the forms of unfair behaviors that constitute violence.

Other MHP attributed men's apparent under-reporting to patterned elements within the cycle of partner violence. As discussed in Chapter One, characteristics of the reconciliation (or "Honeymoon") stage of the cycle of violence (Walker, 1979) include an abusing partner's temporary suspension of

violent behavior, accompanied by promises to permanently end this problematic behavior. The function of the abusive partner's apparent reconciliation serves to assuage concerns of the abused partner. However, these promises are short-lived, as tension continues to build prior to a subsequent violent incident. It is while in this reconciliatory period that MHP often felt resistance from MSR/V to acknowledge the grave toll of violence in their relationships.

These findings implied that MHP and MSR/V should be made aware of both partners' use of violence as it occurred throughout the extent of their relationship (i.e., not just on discrete occasions). In other words, it appeared necessary to design a tool whereby the awareness of both MSR/V and MHP could be raised regarding the interaction of violent behaviors between partners, and how these interactions were patterned throughout the context of an entire relationship.

Previously designed measures, including the widely used Conflict Tactics Scales (Strauss et al., 1996), have been praised for documenting violent behaviors enacted by each partner but also criticized for failing to contextualize the severity, pattern, or inter-relatedness of these behaviors throughout the course of a particular relationship (Cook & Goodman, 2006). I created the Relationship Timeline activity to assist both MSR/V and MHP in identifying the presence of unhealthy and imbalanced patterns of power and control. I also designed this element to capture the emergence of different forms of violent behaviors used throughout the course of the relationship. Feedback from MSR/V reflected the "eye opening" nature of this tool in providing them with opportunities to view the

presence of unhealthy patterns of power and control, sometimes even earlier than they were previously aware.

Shame and Social Desirability in IPV Screening

Participants discussed how the establishment of client-trust and rapport influenced the effectiveness of IPV screening. Several MSR/V discussed that during their initial IPV-related screening or assessment they were “not feeling ready” to discuss the violence in their relationships. These data emerged from narratives of MSR/V who experienced violence from partners as well as those who used violence against their partners. When MSR/V were probed too soon regarding these matters they described several kinds of reactions including minimizing or denying behaviors they felt were unfair, reporting some behaviors but denying the presence of physical abuse, or a combination of both tactics followed by their refusal to return to therapy.

Key informants attributed these phenomena to clients’ feelings of guilt and shame, and tendencies to maintain social desirability within the context of a therapeutic setting. Consistent with findings and implications from previous research is the possibility that MSR/V may feel shame and, therefore, refrain from reporting being targeted by or regular perpetrators of partner violence (McClennen, 2005; Peterman & Dixon, 2003; Relf, 2001). This finding was also consistent with reports by heterosexual, opposite-gender couples. Among these couples, abusing men often underreport their use of violence while women targeted by partner abuse will over-report their use of violence, even in cases

when this violence occurs on discrete instances and in the context of self-defense or retaliation (Cook & Goodman, 2006; Straus et al., 1996).

According to MHP key informants, the accuracy of self-reported partner violence is influenced by the order in which MSRVS are asked to report their use of violence versus that of their partner. Specifically, inquiring about a client's experience of IPV victimization (e.g., "Tell me about what violence you've experienced from your partner.") before inquiring about their perpetration of violent behavior reportedly increases the likelihood that abusing partners will under-report their abuse in comparison to violence used by their partners. Engaging in this order of questioning was also believed to precipitate the over-reporting of violence by partners with behavioral profiles indicative of a "victim" of partner violence.

To address this concern, I designed the screening tool with instructions for the clinician to first inquire about the violent behaviors used by the client before inquiring about the client's receipt of violence from a partner. Overall, key informants appeared to appreciate this element of the screening tool. MSRVS reported that it offered a way in which to contextualize their use of violence versus that of their partner.

Another aspect of establishing client-therapist trust and rapport related to the therapist's use of language. MSRVS and MHP discussed how therapist's use of terms like "violence" or "abuse" was often ill received by MSRVS as terms that were either too harsh or non-applicable. Thus, the use of therapist's language and

terminology had potentially negative implications for the client-therapist rapport and trust-building dynamic.

Therefore, according to findings from Stage One, effectively screening for IPV in MSR/V was largely influenced by the therapist's ability to defuse the defenses of the client and establish a bond within what was often the initial intake evaluation. When attempting to establish rapport and trust with such MSR/V, MHP acknowledged the importance of paying attention to one's language as well as client's cues regarding their readiness to discuss IPV. Yet, MHP also acknowledged that in following the client's "pace" a MHP also faced the client's potential avoidance of discussing IPV dynamics. Such avoidant behavior on the part of the client would prevent a MHP from assessing the degree to which the client's (or his partner's) safety was at risk.

I addressed this problem area by optimizing the privacy afforded to the client regarding their use or experience of partner violence. The flashcards, which provided the client with an opportunity to independently view acts of violence "at their own pace," were praised in key informant feedback data for being both private but non-evasive in probing acts of partner violence.

Paying attention to the concern regarding the use of language and terminology that may be considered too harsh, I euphemistically referred to acts of violence and abuse as acts of "unfairness." In an attempt to be more culturally-responsive and inclusive of same-gender couples, I also designed the tool to be tailorable with respect to the term by which client's refer to their intimate partner, as well as the name they would provide. Key informants did not provide specific

negative or positive feedback regarding these considerations—an omission that may infer the success of these measures in establishing trust and rapport.

The three areas that key informants reported as problematic to effective screening of same-gender IPV related to (1) their lack of knowledge and awareness regarding same-gender IPV, (2) a lack of awareness regarding the patterned course of same-gender IPV, as well as (3) problems related to client-therapist rapport. These problem areas were influenced by factors that were discussed within this chapter, including: heteronormative biases, inadequate context-based understandings of violent incidents, and shame and social desirability-related factors on the part of MSR/V. I highlighted ways in which the preliminary behavioral screening measure addressed these issues, as well as the ways in which key informants received the measure. I continue with a brief discussion of the implications of the study's findings for clinical practice and community-based research.

Study Implications

This study was the first known investigation to result in the creation of a behavioral tool intended to screen for instances of partner abuse in MSR/V. The creation of this screening tool, as well as the process by which it was created, resulted in several notable implications for clinical practice and social change. I provide a description of these implications beginning with the clinical implications of the screening tool.

The first implication involves the tool's potential to increase the assistance of gay/bisexual men who may or may not recognize their involvement in a

relationship characterized by IPV. Whether it is used with MSR/V who regularly experience or regularly use partner violence, this measure may serve as the first step from which clients can begin their recovery from violence. The MHP who administer this screener can provide appropriate referrals for therapy where clients can receive resources related to psychotherapy, case management, safety planning, or batterer intervention.

Aside from its implementation during an initial intake, the tool developed in this study also has the potential to benefit clients who are already engaged in psychotherapy. This was a specific feedback recommendation offered by key informants. The flexibility of the tool—to function well in both intake and therapeutic settings—was also consistent with testimonies of MSR/V who reported having different behavioral health needs with respect to IPV. That is, some MSR/V shared their interest and satisfaction with utilizing psychotherapy to understand the etiology of their involvement with IPV, while others were interested in addressing immediate needs (usually with respect to safety) rather than exploring an etiological root of their IPV involvement.

Applying a wide clinical scope, this tool benefits both MSR/V and MHP through the use of its culturally appropriate language and scripts. For example, the interview guide provides MHP with scripted prompts containing culturally appropriate language and terminology to use when screening MSR/V (e.g., “What term do you use when referring to your intimate partner? (e.g., boyfriend, lover, partner, etc)”) The inclusion of such prompts resulted from Stage One findings, where key informants described challenges in establishing client-therapist trust

and rapport due to MHP being unfamiliar with same-gender IPV. For MSR/V, appropriate language ensures that they are made comfortable when prompted by MHP, some of whom may possess little familiarity engaging MSR/V in discussions regarding partner violence. For MHP, the screening tool's incorporation of appropriate language and prompting ensures that MHP can accurately screen for same-gender IPV in MSR/V regardless of their clinical experience or comfort level working with this population.

Aside from clinical implications, the tool also has social change implications. Second order change, a major tenet of community psychology, is accomplished when problems related to the person-environment fit are resolved by attending to systems and structures that may be exacerbating or maintaining the problem (Watzlawick, Weakland, & Fisch, 1974, as cited in Dalton, Elias, & Wandersman, 2001). This resolution is often achieved through research whose findings translate into transformative policy.

The behavioral screening tool created in this study has the potential to effect second order change related to how the mental health system interacts with MSR/V. As discussed in Chapter One, current community-based programs intended to address IPV in MSR/V compartmentalize this population into two subcategories: those who are “victims” of partner violence versus those who are “perpetrators” of partner violence. Also as discussed in Chapter One, Ristock (2002) has critiqued these programs for mandating that MHP adhere to what she refers to as “necessary speech” (i.e., grant-mandated stipulations to serve either “victims” or “perpetrators” of IPV). The reality, even as supported through the

findings from the current study, is that individuals involved in IPV relationships do not fit exclusively within either category of victim or perpetrator. “Victims” who use occasional violence, and “perpetrators” who experience violence may not receive necessary aid as their behavioral profiles may render them ineligible for programming as it is currently designed.

In terms of second-order change, this screening tool can broaden the way IPV is conceptualized and addressed in community mental health and other social service settings. The tool created in this dissertation, unlike other measures commonly used to assess for IPV (i.e., CTS2), does not attempt to simply assign MSR/V into either a category of “victim” or “perpetrator.” Instead, the FARE Screener provides MHP and MSR/V with an opportunity to understand the context of the partner violence MSR/V have used and/or received. Perhaps, through its regular and consistent implementation, MHP who administer the FARE Screener will become more aware of the nuanced ways in which partner violence manifests in gay/bisexual males. This awareness will, then, result in a MHP-led movement to create community-based programs that comprehensively address IPV in all MSR/V, including those who would otherwise be categorized as “victim” or “perpetrators.”

In the participatory process by which the FARE Screener was created lies an implication for second-order change. Specifically, the involvement of MSR/V and MHP in this study highlights the potential ways in which these two populations can be mobilized to effect change in mental health care services and mental health training. MSR/V who participated in this study engaged in critical

discourse regarding the strengths and pitfalls of screening and assessing same-gender IPV within the current community mental health care milieu. MHP shared similar criticisms, but also provided a narrative critiquing their IPV-related training for being replete with heteronormative bias and an acontextualized formulation of same-gender IPV. The continued engagement of these two groups of key informants will be necessary to ensure the continued improvement of mental health and social services for MSR.V.

Strengths and Limitations

There are important strengths and limitations of the current study, which are highlighted in this third component of the discussion. One major strength of this study was its reliance on a participatory framework that included two groups of key informants, each with “expertise” that informed the creation of the behavioral screening tool.

A second major strength of the current study concerned the richness of the data shared by each of the key informants—16 MSR.V and four focus groups of MHP. The phenomenological exploration of contextual factors associated with same-gender IPV would not have been possible with the use of non-qualitative data. The importance of this phenomenological approach was key to exploring understudied occurrences like IPV in same-gender male couples.

A third major strength of the study was its participatory design, consisting of repeated points at which both phenomenological and feedback data were collected from a subsample of MSR.V and MHP. The findings from these data, paired with findings from key informants who participated only in the final data

collection phase, ensured that the final screening tool reflected a variety of important screening issues faced by MSRV and MHP alike.

It was also a valuable strength of the current study to be conducted using a multiethnic, community-based sample. With rates of IPV in gay/bisexual men being largely unreliable, and programming aimed toward this population being virtually non-existent, it was especially important to broaden participation to as diverse a sample as possible. Study strengths aside, several limitations of the study are important to consider.

Related to the diversity of the sample, one major limitation was that it was heavily weighted with MSRV who were predominately low-income, African Americans and MHP who were predominately European American. While the MSRV sample was also comprised of European American men, the sample consisted of only one Latino male participant, and no men of Asian, Native American, Asian-Pacific Islander, or multi-racial/multi-ethnic backgrounds were represented. The MSRV sample also consisted of men who identified as “gay/homosexual,” with two men identifying as “bisexual.” The sample of MHP key informants was nearly comprised of people from European American backgrounds, which was problematic given the wide range of diverse communities served by social services in Chicago. A greater array of culturally-responsive considerations may have emerged from a sample comprised of participants from a greater range of sociocultural and socio-demographic backgrounds.

I believe the homogeneity of the sample was due to several factors. I believe my recruitment from community-based, social service organizations accessed primarily by low-income, African American men who have sex with men (MSM) contributed to my predominately African American sample of MSRV. The lack of diversity with respect to MHP was most likely due to the scarcity of mental health providers of color employed at the venues at which I promoted and recruited the study. In fact, the one MHP of color (an African American, lesbian woman) who participated in Stage Three was unemployed at the time of her study participation. This participant reported learning of the study from a colleague who thought she might be interested in the topic.

Another study limitation also related to the study sample. The current study sample was comprised of 26 key informants, 10 of which were MHP and 16 of which were MSRV. While saturation, or a consistent re-emergence of salient themes, was adequately reached within this study, a greater level of saturation may have been reached within a larger and more diverse sample of participants.

In addition, the majority of the sample was comprised of adult men who identified as gay, with only two men under age 25, and only two that identified as bisexual. Future research among this population may benefit from including a greater number of young men with histories of relationship or dating violence. Replicating this study among a larger sample that consists of greater ranges in age and sexual identity status could also engender a greater saturation of results from comparative analysis of MSRV from each of these backgrounds. However, it is

important to note that saturation can also be reached within a small sample that is comprised of well-represented groups.

Another limitation concerns the measures non-applicability to intimate relationships that may involve more than two partners. The best recommendation in such cases is to administer the FARE Screener once for each of the presenting client's partners. As it is currently designed, following this recommendation would make for an extremely long, labor intensive, and obtuse process.

A limitation alluded to earlier in this chapter also involves the FARE Screener not being available to people who are illiterate, non-English reading, and people who may have low reading levels. While MHP can administer the FARE Screener aloud, certain aspects of it (i.e., the selection of flashcards) could have a significant negative impact on implementation time and increase that likelihood that MSR/V will be influenced by factors related to social desirability (i.e., and not accurately report instances of violence). One recommendation is that the screener includes graphic representations (i.e., pictures/drawings) to convey certain concepts. This is particularly true when featuring various examples of violence on each flashcard. While some violent behaviors may be easier to graphically represent than others (e.g., "stabbing" versus "threatening to disclose sexual identity to others"), making these changes would be beneficial as they would greatly retain the privacy afforded the client and minimize the screener's administration time.

A final limitation concerns the use of the Timeline Followback (TLFB) approach to the Relationship Timeline activity. TFLB has been criticized for

relying solely on a client's self-report and retrospective memory pertaining to extended periods of time, raising concerns regarding the influence of maturation effects and social desirability in minimizing substance use (Carey, Carey, Maisto, Gordon, & Weinhardt, 2001). This critique could also be true for the TLFB approach when implemented to account for another socially undesirable experience: one's personal history of IPV use or receipt.

Directions for Future Research

Future research on the behavioral screening of same-gender IPV should extend the application of the tool developed in this study to lesbian, bisexual, transgender, and intersex populations. The feasibility of such an endeavor would be high, requiring minimal modification of the existing screener. However, one area where additional phenomenological inquiry would be advantageous would involve inquiring about specific forms of partner violence that may be unique to lesbian women, transgender individuals, and people of all genders who are bisexual or intersex.

On a related note, future research should also use the tool created in this study as the basis for a similar instrument targeting IPV in opposite-gender, heterosexual relationships. Although this population is most heavily studied, it could also benefit from a contextual and nuanced approach to understanding forms and patterns associated with IPV. As demonstrated in this study, this tool would likely rely less on a heteronormative bias that is based on a traditional feminist ideology. It would also help to recognize gender symmetrical patterns of

IPV that have been noted by those who conduct research in this area (Hamel, 2007).

As it stands now, IPV-related research on gay/bisexual men has been largely underrepresented in the literature, while the studies that do exist present inconsistent epidemiological data concerning rates of same-gender IPV. Given the inconsistencies of these studies, the body of research pertaining to same-gender male IPV has failed to impact policy that addresses the needs of MSRV. While my dissertation attempts to improve the way in which same-gender male IPV is assessed, it lacks that structure and brevity that would optimize its use in research settings.

Future research in this area should, therefore, also focus on developing the screening tool developed in this study into a more structurally-sound behavioral measure to be used in research settings. This screening tool could be developed as a paper-and-pencil instrument that resembles the FARE Screener. However, the tool can also be modified into a computer-assisted self interview (CASI) that guides the participant through a series of questions and activities related to his use and experience of IPV. Perhaps, this CASI can also be developed for use with “smart” devices (i.e., tablet computers) that employ touch screens upon which a participant can “sort” through an electronic deck of unfair behaviors, as well as “plot” these behaviors onto an electronic version of the Relationship Timeline.

Regardless of the specific medium, the development of this research tool is especially important given the inconsistent estimates of IPV incidence and prevalence cited in Chapter I. The creation of such a measure could extend this

study's potential for galvanizing second order change with respect to same-gender IPV; fostering an accurate portrayal of same-gender male IPV in research and, thereby, leading to the funding and creation of community-level intervention and prevention programs to address this public health issue.

CHAPTER V

SUMMARY

As with other mental health issues affecting lesbian, gay, bisexual and transgender (LGBT) populations, a dearth of literature exists pertaining to intimate partner violence (IPV) within these communities. Among gay/bisexual males in the United States, IPV has been estimated to be among the top three health issues impacting their communities. Previous studies of IPV among male couples have had methodological flaws in sampling, which have led to inconsistencies in IPV incidence and prevalence among this population. In addition, behavioral tools often apply a heterosexist and prototypical model to screening for IPV; thereby, failing to contextualize occurrences of violence in a same-gender IPV relationship. This inattention to context and same-gender dynamics results in the mis-categorization of individuals within a narrowly defined victim-perpetrator binary.

Despite the estimated impact of IPV among gay/bisexual men, no known literature has attempted to create a behavioral screening tool that accounts for contextual factors in same-gender relationships characterized by IPV. The current study addressed this gap in the science by determining the essential theoretical constructs of a clinical screening tool for males involved in same-gender IPV relationships. The constructs of this tool were based on the literature cited in Chapter One, in addition to the qualitative data of two groups of key informants—men who have been in same-gender relationships involving partner violence

(MSRV), as well as mental health providers (MHP) with varying degrees of experience treating this population.

Data collection and analysis occurred in four stages of this dissertation. In the first stage, key informants participated in individual interviews (MSRV) and focus groups (MHP), providing insights regarding how they defined same-gender IPV, their experiences screening or being screened for same-gender IPV, and their recommendations for the effective screening of IPV in MSRV. Results from this first stage of the study indicated that a behavioral screening tool should address the general lack of knowledge demonstrated by MSRV and MHP regarding IPV. Stage One findings also highlighted the need for a behavioral screening tool to raise awareness on the parts of MSRV and MHP regarding the patterned course of power and control dynamics within a same-gender IPV relationship. Last, the initial findings suggested that a screening tool aim to establish trust and rapport between client and therapist.

In the study's second stage, I employed findings from Stage One to develop a preliminary behavioral screening tool. This tool consisted of a structured interview guide that followed a skip-patterned itemization flow. The screening tool was also composed of two decks of flashcards and a chart graphic that represented both violent behaviors (i.e., the flashcards) and forms of partner violence (i.e., the "Chart of Unfair Behaviors" graphic). The final element of this screening tool consisted of a relationship timeline graphic designed to capture the severity, frequency, and course of IPV as used and experienced by both partners over the extent of a relationship.

In the study's third stage, I piloted the preliminary screening tool with key informants (some of whom participated in Stage One) and collected their feedback related to the measure's content, format, and structure. The fourth and final stage of the study involved my refining the screening tool based on feedback offered from key informants who participated in Stage Three.

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Appendix A

Power and Control Wheel "The Duluth Model"



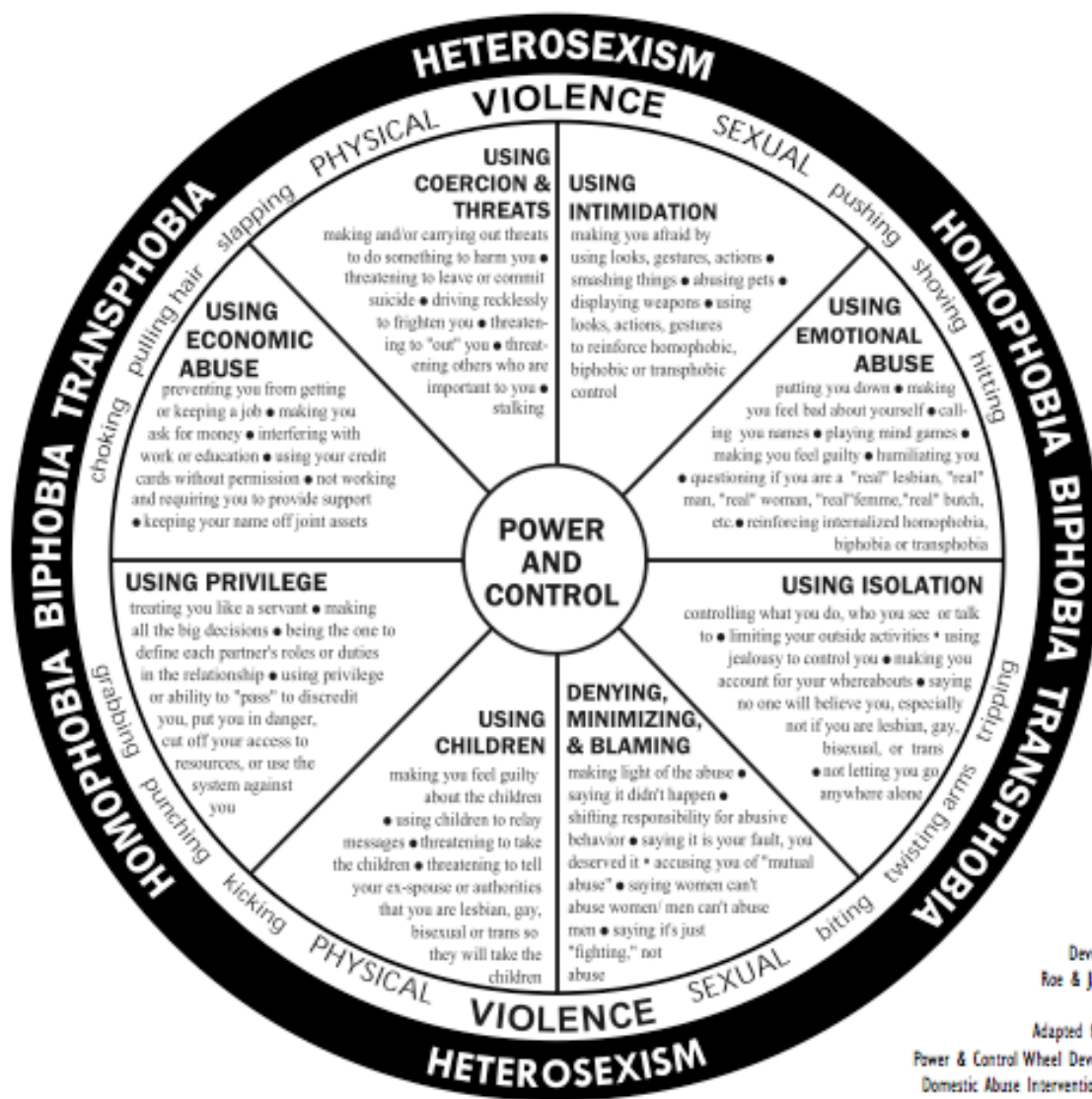
DOMESTIC ABUSE INTERVENTION PROJECT

202 East Superior Street
Duluth, Minnesota 55802
218-722-2781
www.duluth-model.org

Appendix B

Power and Control Wheel for LGBT Relationships

Power and Control Wheel for Lesbian, Gay, Bisexual and Trans Relationships



Developed by
Roe & Jagodinsky

Adapted from the
Power & Control Wheel Developed by
Domestic Abuse Intervention Project
206 West Fifth Street
Duluth, MN 55806

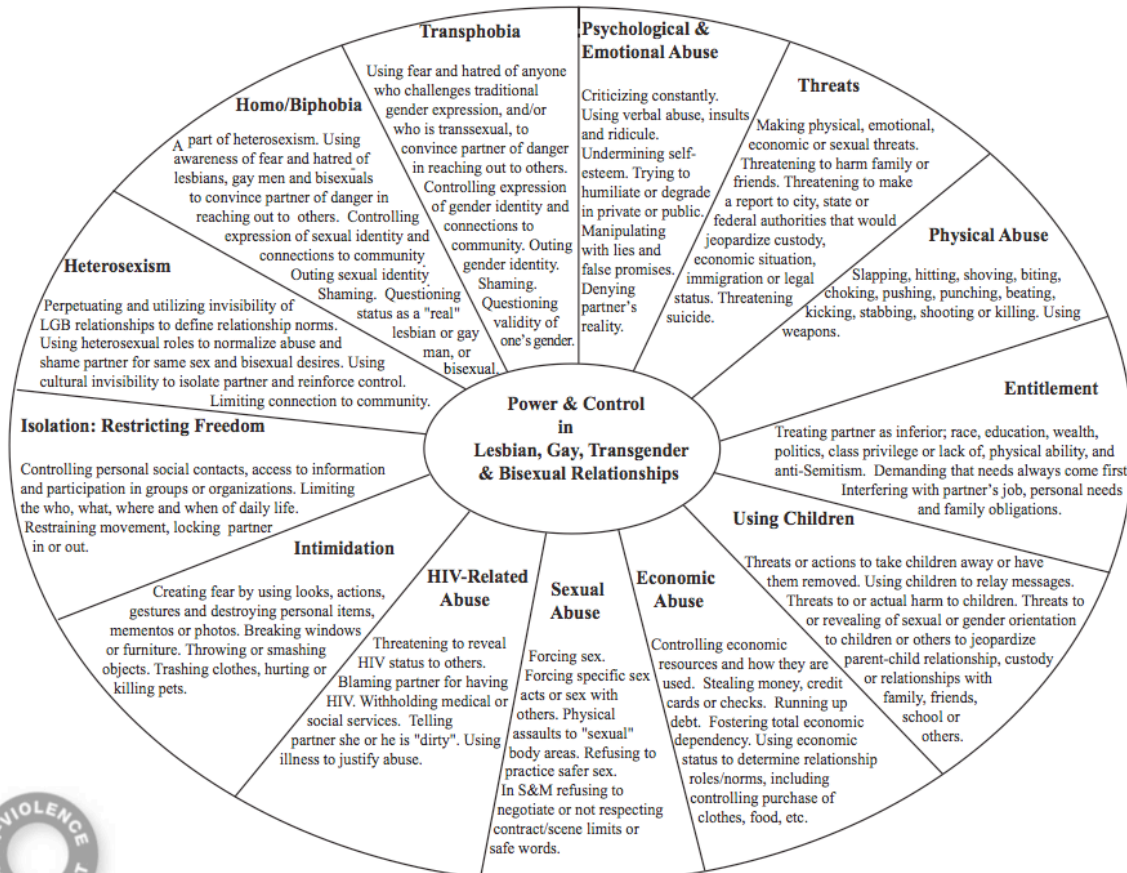
Adapted by:



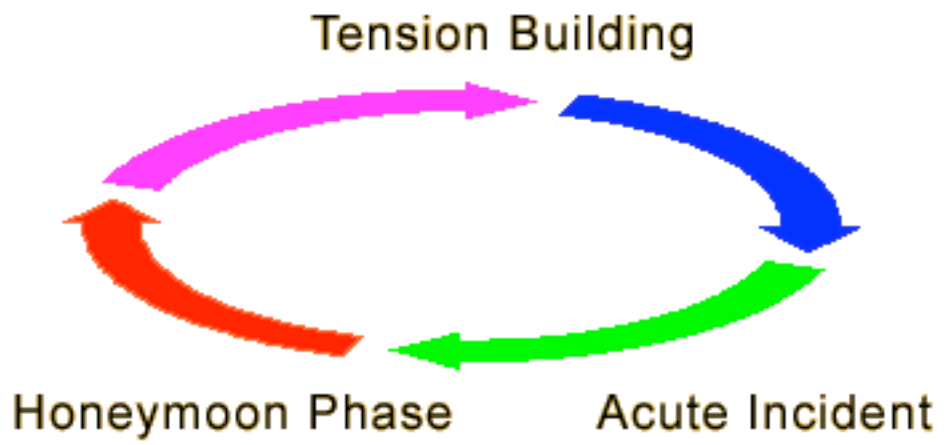
P.O. Box 161810 • Austin, TX 78716
512/794-1133 • Fax: 512/794-1199

Appendix C

Power & Control in LGTB Relationships



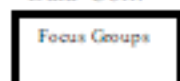
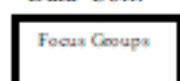
Appendix D
The Cycle of Violence



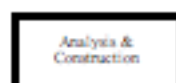
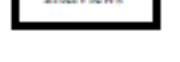
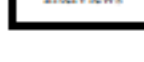
Appendix E
Study Design

STUDY ONE**Stage 1— Qualitative data collection.**

- Focus groups (N=4) with providers who work with survivors/perpetrators of same-gender IPV; and
- Individual in-depth interviews (N=10) with people who have experienced IPV in a relationship (both self-identified perpetrators and survivors).

Stage 1**Data Coll.****STUDY TWO****Stage 2—Measure construction based on data from stage 1.****Stage 1****Data Coll.****Stage 2****Measure Construction****Stage 3—Key informant feedback on constructed measure.**

- Focus groups (N=4) with providers who work with survivors/perpetrators of same-gender IPV; and
- Individual in-depth interviews (N=10) with people who have experienced IPV in a relationship (both self-identified perpetrators and survivors).

Stage 1**Data Coll.****Stage 2****Measure Construction****Stage 3****Feedback on Measure****Stage 4—Refinement of behavioral assessment through integration of data from stage 3.****Stage 1****Data Coll.****Stage 2****Measure Construction****Stage 3****Feedback on Measure****Stage 4****Measure Refinement**

Appendix F
Eligibility Screening Questionnaire

(03/2009)

SCREENING INTERVIEW

SCREENING DATE: [] [] [] [] [] [] [] [] [] []
Month Day Year
SCREENER INITIALS: [] [] **SCREENING PHASE:** In Person | Phone | Confirmation in Person
(Circle one)

My name is Marco Hidalgo and I'm conducting a research project to learn more about how to improve the services that are made available to men who are in relationships involving intimate partner violence (sometimes called domestic violence). Are you interested in hearing more about it?

Response: If yes, continue. If no, thank them for their time and discontinue screening.

Thanks for your interest in this study. The purpose of this study is to learn how to improve the mental health services that are available for males who are in relationships involving same-gender intimate partner violence.

If you are eligible and decide to participate in this study all of your information will be kept confidential and only myself and other researchers working on this study will have access to this information. No one else will be told about your participation in this study.

Please remember that participation in this research study, including answering any of the following questions, is completely voluntary. You can refuse to answer any of the questions or decide that you do not want to participate at any time. If you have questions about this research project you may contact the supervising researcher of this project, Dr. Gary Harper at (773) 325-2056. You may also direct your questions, comments or concerns to Dr. Susan McMahon, Chair of DePaul University's Institutional Review Board, at (773) 325-2039.

To find out if you're eligible to participate in this study, I'll need to take less than 5 minutes to ask you some questions. Your answers to these questions will be kept confidential. One of the reasons I stress confidentiality is that I will be asking some very personal questions, and it is very important that you be as honest and as accurate as you can be with your answers.

It is only if you are eligible and interested in participating that I will ask for your name and date of birth.

Are you willing to answer some questions to determine if you are eligible for the study?

Response: If yes, continue with Screening Questions. If no, ask for reasons why:

- | | | | |
|--|----|--|----|
| <input type="checkbox"/> No interest | 01 | <input type="checkbox"/> Afraid of research/guinea-pig | 04 |
| <input type="checkbox"/> Worried about anonymity | 02 | <input type="checkbox"/> Rather not say | 05 |
| <input type="checkbox"/> Study takes too long | 03 | <input type="checkbox"/> Other | 06 |

If other, specify _____

INSTRUCTIONS: This screening interview may be conducted in person or by phone. If eligibility is determined by phone, participants must make an appointment to reconfirm their answers to the screening questions in person before signing consent. Subject ID numbers will only be assigned (a) after the screening questions determine the volunteer to be eligible for this study and (b) after the participant signs the consent form. Regardless of whether or not the participant is eligible, record the participant's responses to all questions.

(03/2009)

RECRUITER INITIALS: _____ SCREENING DATE: _____
 Month Day Year

B. FOCUS GROUP SCREENER

(NOTE: Administered only to volunteers interested in serving as key informants who are mental health providers)

1. First, how old are you?

_____ years *(If participant is under 18, check ineligible and continue)* Ineligible

2. Are you able to understand both spoken and written English?

3. Have you ever provided any counseling or therapy to men regarding issues related to their intimate partner violence with other males?

Yes

No *(Check ineligible and continue)*

Ineligible

(If "Yes" to question 4 ask the following)

I'd like to ask you more about your past experiences providing therapy or counseling to males involved in same-gender IPV. Please respond "yes" or "no" to the following questions:

a. Did you personally conduct a behavioral assessment with these clients?

Yes → Please specify type of assessment: _____

No *(Check ineligible and continue)* Ineligible

b. Which of the following best describes the setting in which you have provided services to males involved in same-gender IPV (you may choose more than one):

Private practice Hospital setting

DV shelter Other shelter/housing facility (e.g., recovery facility)

LGBT health org. Non-LGBT health org.

Other (Please specify: _____)

NOTE: If no boxes above have been designated as ineligible, proceed to page 5 to continue screening.

(03/2009)

RECRUITER INITIALS: [][] [][] SCREENING DATE: [][] [][] [][][][]
 Month Day Year

The following three questions are for the interviewer only.

DO NOT ASK THESE QUESTIONS OF THE VOLUNTEERS.

1. Does the volunteer appear cognitively functioning and able to understand the consent process?

- Yes (*Check ineligible and continue*)
 No

Ineligible

2. Does the volunteer appear visibly distraught or emotionally unstable (i.e. suicidal, manic, exhibiting violent behavior)?

- Yes (*Check ineligible and continue*)
 No

Ineligible

3. Does the volunteer appear intoxicated or under the influence of psychoactive agents?

- Yes (*Check ineligible*)
 No

Ineligible

INSTRUCTIONS: If any of the above ineligible boxes are checked, read the INELIGIBLE section. If none of the boxes are checked, read the ELIGIBLE section below.

FOR INELIGIBLE VOLUNTEERS:

Participants for this research project are selected based on the questions you were just asked. Based on your answers, it turns out you're not eligible to participate. Thank you for taking the time to talk with me about our study.

FOR ELIGIBLE VOLUNTEERS:

Thank you very much for the information you provided. Based on your answers to these questions, you are eligible to participate in this research study. That means that if you want to participate you may. Do you think you might be interested in taking part in this study?

Response: If "No", thank them for their time. If "Yes":

For screenings conducted by telephone, give volunteer information about when and where to complete an in-person screener, consent, and participate.

For those screened in person say, **Before we go any further, I need to review a consent document with you.**

Appendix G
Contact Information Sheet

CONTACT INFORMATION FORM

INSTRUCTIONS: This form should be completed by study staff, with the help of the participant. Tell the participant: **The information you provide will help us get in touch with you throughout your participation in this study. I'll be asking for your contact information as well as the contact information of trusted friends and/or family members. In most cases we will use only your contact information, and only rely on the information of others in the event that we are not able to contact you. This is confidential information that will only be used by the members of the our team, and not shared with anyone else. The information will be securely stored, and destroyed after your completion of the study.**

1. Name _____

First
Middle
Last
2. What do your friends/acquaintances call you? _____
3. Address: _____

Street Address
Apt. #

City
State
Zip Code
4. E-mail address: _____
5. Instant Messenger Screen-name: _____
6. Cell Phone Number: _____ Can we leave a voice message? Yes
 No

Can we send a text message? Yes
 No
7. Home Telephone Number: _____ Can we leave a message? Yes
 No
8. Work Telephone Number: _____ Can we leave a message? Yes
 No
9. Pager: _____ Can we page you? Yes
 No
10. How do you prefer to be contacted? _____ (Circle the # of your preference 4-8 on this page)
11. How many times (apart from the standard 3 attempts) may we attempt to contact you? _____
12. Best times to call:
Su M T W Th F S Between _____ : _____ a.m./ p.m. and _____ : _____
a.m./ p.m.
Su M T W Th F S Between _____ : _____ a.m./ p.m. and _____ : _____
a.m./ p.m.
13. If someone besides you answers the phone, what should we say? _____

CONTACT INFORMATION FORM (cont.)

Contact #2
(This person should be a trusted adult)

21. Name: _____
First Middle Last

22. Address: _____
Street Address Apt. #

_____ City State Zip Code

23. Home Telephone Number: _____ Can we leave a message? Yes
 No

24. Cell Phone Number: _____ Can we leave a voice mail? Yes
 No

Can we leave a text message? Yes
 No

25. Work Telephone Number: _____ Can we leave a message? Yes
 No

26. Pager: _____ Can we page this person? Yes
 No

Can we leave a message? Yes
 No

27. What message should we leave? _____

Appendix H
Semi-structured Guide for the
Individual In-depth Interview

Individual In-depth Interview Guide

STAGE 1: Date: __/__/__

Participant ID # _____

Thank you for agreeing to participate in this interview concerning same-gender male relationships where abuse occurs. Remember that this interview will help to improve the services offered to other men who've been in relationships where abuse occurs.

You were asked to participate in this study because you have personally experienced violence in a relationship with another man. I realize that it's not always easy to talk about something so private, but remember that everything you tell me is completely confidential. Please keep in mind that this is a safe place to discuss private things without feeling judged in any way. Unless you have any questions, we can begin.

1. How do you define "violence" (or "domestic violence") within a relationship involving two men?
 - a. Probe: What experiences have you had in relationships that you'd consider "partner violence"?
2. The terms "victim" and "survivor" are used a lot when referring to people who have experienced intimate partner violence. What term do you use when referring to yourself as someone who experienced IPV? Why?
3. How, if at all, do things like age, ethnicity, relationship length, or HIV status influence intimate partner violence among gay/bisexual men?
4. In your opinion, what are the common issues that males involved in same-gender IPV face when seeking help?
 - a. Probe: If you've sought help, what've been issues you've faced? [Note to facilitator: these may relate to family or macro-level issues (e.g., lack of programs).]
5. When you sought help for issues related to partner violence, what was it like to talk about partner violence with a mental health professional for the first time?
 - a. Probe: Tell me your impressions about how competent they were at understanding your relationship in that initial meeting.

6. When you sought help for issues related to IPV, what important questions did you feel were NOT asked of you?
7. Alternatively, which questions were asked of you that you felt were not important?
8. Let's switch gears now, and talk more about the process of that first meeting with a therapist. Share with me your impressions about how well the format of talking about partner violence in that first meeting went for you?
 - a. Probe: For example, if you filled out a questionnaire on your own, you might have preferred a format where you were asked similar questions by a therapist. Please share with me thoughts related to your experience in this meeting.
9. Looking back to that experience, what suggestions would you make so that a person seeking help for the same reason you were may have an even better experience?

If participant declines to answer a question, reassure them by stating the following:

Some of these questions can spark memories or experiences that are sometimes difficult to talk about. You're welcome to skip a question entirely, or just come back to it later. Remember that this interview is completely confidential.

Appendix I
Semi-structured Focus Group Guide

Focus Group Guide		
STAGE 1—Date: ___/___/___		
Participant ID # _____	Participant ID	
# _____	Participant ID # _____	Participant
ID # _____		

Thank you for agreeing to participate and share a little bit about your experiences working with males involved in same-gender relationship where violence occurs. During this focus group, I will be asking questions pertaining only to your experiences working in therapy/counseling relationships with males who are involved (or were involved) in relationships involving same-gender partner violence. Remember that each your experiences are valuable in helping to improve the domestic violence services offered to men involved in same-gender relationships.

To assure the confidentiality of your clients, please refrain from using any identifying information when sharing any clinical case material. I realize that many of us come to this field for many reasons, including some related to our personal histories. Remember that this is a confidential setting and that everything you share here will remain confidential, and should not be repeated to others. Unless you have any questions, we can begin.

1. How do you define “partner violence” in the context of a relationship involving two men?
 - a. How, if at all, is this definition different from the definition of “partner violence” involving heterosexuals?
 - b. How did you come to define same-gender partner violence in this way?
2. In your opinion, what are the forms of abuse that are characteristic of same-gender male IPV?
 - a. Probe: What signs do you look for when assessing IPV?

Several terms are used a lot when referring to people who are involved in intimate partner violence.

3. What terms do you use when referring to someone who reports violence being used against them by an intimate partner?
 - a. Please share your impressions about how accurately you feel these terms reflect the experiences of your clients?
4. What terms do you use when referring to someone who reports using violence against an intimate partner?

- a. Please share your impressions about how accurately you feel these terms reflect the experiences of your clients?
5. What are some unique aspects of assessing IPV in the context of same-gender male couples?
 - a. Probe: In terms of intimate partner violence, what do same-gender male couples experience that may be different from opposite-gender couples?

Let's switch gears now, and talk more about the tools you use to assess partner violence in the context of a relationship involving two men.

6. First, what are some examples of what you typically ask in an assessment of partner violence?
7. At what point do you typically begin to assess for partner violence?
 - a. Probe: In other words, do you wait until you have heard signs of IPV, or do you always screen for IPV history regardless of what is said about an individual's current or past relationship?
8. From your clinical experience, what are important topics that should be included in a behavioral assessment sensitive to IPV among male-male couples?
 - a. Probe: What aspects of potential violence between male partners may not exist on a more typical IPV assessment?
9. In your opinion, what should be the format of a measure to assess same-gender IPV among males?
 - a. In other words, what are your thoughts about whether an assessment should be self-administered, an interview format, or a combination of both self-report and interview?
10. In your opinion, what content areas should be included on a measure to assess same-gender male IPV?
11. How should a measure to assess same-gender IPV among males be structured?
 - a. What format would work better—closed- or open-ended items? And why?

Appendix J
Questionnaire

Date: ____/____/____ Participant ID# _____

Please complete the following information. This information you share on this questionnaire will be kept confidential. Please follow the instructions in the boxes, and hand your completed survey to interviewer when you are finished.

Section A. For each of the following 5 questions, please indicate the box that that best describes **your background**

1. How old are you? _____

2. How do you identify in terms of your gender identity? (please check only one)

₁ biological male ₂ biological female ₃ transgender M-to-F ₄ transgender F-to-M

3. How do you identify in terms of your sexual orientation or sexual identity?

4. How do you most commonly identify in terms of your race/ethnic background?

5. What is the highest level of education you've obtained?

- ₁ Junior High/Middle School
- ₂ High School/GED
- ₃ Some College
- ₄ College Degree
- ₅ Graduate/Professional Degree

6. In the space below, please provide any feedback on your participation in the study thus far. This information may relate to topics covered in the interview/focus group, or other thoughts you may have related to same-gender IPV.

Section B. The following questions pertain to Mental Health Providers (MHP) only. If you have been recruited to participate in this study as a MHP, please complete the questions below.

1. Where did you receive training on issues related to IPV?

Response: _____

2. When you received training on issues related to IPV, were you also trained on how to conceptualize IPV among same-gender couples?

Yes **No**

If "YES," did your training include issues relevant to male-male couples?

Yes **No**

3. Of those whom you serve who have been involved in same-gender IPV, what percentage would you estimate to be men? _____%

a. What percentage of these men report *experiencing* abuse (i.e., being "victims")?

_____%

b. What percentage of these men report *using* abuse (i.e., being "perpetrators")?

_____%

c. What percentage of these men report *both* experiencing and using abuse (i.e., being both "victims" and "perpetrators")?

_____%

Appendix K
Assessment Feedback Guide

Assessment Feedback Guide

I. INTRODUCTION [5 mins.]**❖ PREAMBLE TO BE READ IN INTERVIEW FORMAT:**

Thank you very much for agreeing to participate in today's interview, and thank you again for the information that you have already provided during your participation in the earlier stage of the study. Today, I will be sharing a behavioral assessment that will help mental health providers assess same-gender male intimate partner violence. This assessment has been developed based on the information shared by you and others in the first stage of this study. Today, I will be asking for your feedback based on your personal experiences. This feedback will help to improve or modify the assessment so that it can assess gay/bisexual males involved in same-gender IPV relationships.

As a reminder, everything you share during this feedback interview will be kept confidential. This confidentiality will hopefully help to foster an open environment, and an informative feedback interview. If no one has any questions, we'll begin.

PREAMBLE TO BE READ IN FOCUS GROUP FORMAT:

Thank you very much for agreeing to participate in today's focus group, and thank you again for the information that you have already provided during your participation in the earlier stage of the study. Today, I will be sharing a behavioral assessment that will help mental health providers assess same-gender male intimate partner violence. This assessment has been developed based on the information shared by you and others in the first stage of this study. Today, I will be asking for your feedback based on your experiences as providers who have worked with males in same-gender relationships involving intimate partner violence. This feedback will help to improve or modify the assessment that this study is aiming to develop.

As a reminder, everything you share during this feedback interview will be kept confidential. This confidentiality will hopefully help to foster an open environment, and an informative group feedback process.

Since all of you may have different personal and professional backgrounds and orientations, you may not all agree with the information and ideas that are presented. This is okay and something that is expected. I want to make sure that all participants feel safe in today's group so I ask that you treat each other with respect throughout the group. As a reminder, everything you share during this feedback meeting will be kept confidential. So basically what is said in the group should stay in the group. This will help to protect everyone's confidentiality and to create a safe and informative group. To further ensure your confidentiality I will leave it up to you to decide whether or not you introduce yourselves to each other. If no one has any questions, we'll begin.

II. Content Evaluation [55 mins.]

Script to be read to Key Informant(s): *During this portion of the [feedback interview/ focus group], I will quickly walk you through the measure. Please follow along using the copy I've provided to you. Following this brief review, I will ask you more specific questions regarding the content of the assessment.*

- [Review Measure Aloud—5-10 minutes]
- *First, what are your reactions to the content of the behavioral assessment measure?*
 - *How does this measure reflect the content you thought should be included in a behavioral assessment for males in same-gender IPV relationships?*
 - *How does this measure NOT reflect the content you thought should be included in a behavioral assessment for males in same-gender IPV relationships?*
 - *Are there certain parts of the measure's content that are confusing or do not make sense?*
 - *Is there anything about the measure's content that you would change, add, or take away?*

III. Structure and Format Evaluation [45 mins.]

Script to be read to Key Informant(s): *Thank you for sharing that feedback related to the content of the measure. I'd like to switch gears now, and hear your feedback regarding the structure and format of the measure.*

- *First, what are your reactions to the structure of the behavioral assessment measure? When I say "structure" I'm referring to the way the entire measure and items are ordered, or appear.*
 - *What are your thoughts regarding the design of the measure as a whole?*
 - *What are your thoughts regarding the design of the specific items within the measure?*
 - *What are thoughts regarding the order of the items?*

- **What are your reactions to the *format* of the behavioral assessment measure? When I say "format" I'm referring to the how the questions are asked (e.g., open-ended/closed-ended, language used, etc.).**
 - **What are your thoughts regarding how the questions are asked?**
 - **What are your thoughts regarding the way in which questions may be answered (e.g., open-ended or closed-ended/forced choice)?**
 - **What are your thoughts regarding the clarity of the language used in the measure?**
- **How long should the measure take to complete?**
- **What are your recommendations about how the measure should be administered?**
 - **Should it be administered in an interview format, by self-report, combined interview and self-report, or another method? Why?**

IV. CONCLUSION OF FOCUS GROUP [5 mins.]

Is there any other feedback that you would like to share regarding the behavioral assessment measure?

Thank for you for providing me with feedback on the content, structure and format of this behavioral assessment measure. All the important information you've been sharing with me throughout this project will help to improve the mental health services available to men in relationships involving same-gender intimate partner violence.

Appendix L
Debriefing Script

DEBRIEFING SCRIPT FOR IN-DEPTH INTERVIEW

"Several questions in the interview asked you about personal and sensitive information. Some of the questions in the interview may have caused you to think about situations or feelings that I would like to check in with you about. I want to check in with you to make sure that when you leave here today you are feeling okay and that you make safe decisions."

IF THE PARTICIPANT DISCUSSED SUICIDAL THOUGHT/IDEATION/ATTEMPTS, ASK:

"At one point in the interview, you mentioned thoughts or feelings of wanting to end your life. I want to ask you now how you are feeling, and if you are having thoughts of hurting yourself."

If answer indicates suicidal thoughts, feelings, or plan, the interviewer should say, "It's my responsibility to make sure you are safe. I need you to meet with a counselor to make sure you are safe. I will stay with you until s/he arrives." In the event that this study visit occurs at a community-based agency the interviewer should follow agency procedures for acute mental health referrals. Interviewer should contact mental health professional immediately and stay with the participant until mental health professional arrives.

IF THE PARTICIPANT DISCUSSED EXPERIENCING OR USING SOME FORM OF ABUSE TO HARM ANOTHER (HOMICIDE) OR THE INTENTION OF HARMING ANOTHER (HOMICIDAL IDEATION), ASK THE FOLLOWING:

"At one point in the interview, you mentioned (being hurt by someone in the past/someone threatening to hurt you/hurting someone/threatening to hurt someone). I would like to ask you more about this to make sure that no one is at risk of being harmed. Is there anything you would like to say about this abuse?"

If yes, interviewer should say, "I'm sorry that's happening. It's my responsibility to make sure you (are safe/do not cause serious harm to another person). I would like you to meet with a counselor to make sure this does not happen (again). I will stay with you until s/he arrives." In the event that this study visit occurs at a community-based agency the interviewer should follow clinic procedures for mental health and/or potential abuse referrals. Interviewer should contact stay with participant until supervisor or mental health professional arrives. In addition to mental health services/referrals, the mental health professional will provide appropriate information regarding legal protections and services related to the abuse.

ASK THIS QUESTION OF ALL PARTICIPANTS, REGARDLESS OF THEIR REPORTING OF ABUSE AND/OR SUICIDAL THOUGHTS:

"Is there any (other) part of the interview you would like to discuss further?"

If response indicates the participant is in urgent need of mental health assistance, the interviewer should follow clinic/agency procedures for acute mental health referrals. Interviewer should contact the supervisor immediately and stay with the participant until supervisor or mental health professional arrives. Otherwise, interviewer should say, "If you decide that you would like to speak with a counselor, here is a list of agencies in the community that provide this service."

DEBRIEFING SCRIPT FOR FOCUS GROUP

"Several questions in the focus group asked you about personal and sensitive information. Some of the questions in the interview may have caused you to think about situations or feelings that we would like to check in with you about. I want to check in with you to make sure that when you leave here today you are feeling okay and that you are safe."

IF THE PARTICIPANT DISCUSSED SUICIDAL THOUGHT/IDEATION/ATTEMPTS, ASK:

"At one point during the group, you mentioned thoughts or feelings of wanting to end your life. I want to ask you now how you are feeling, and if you are having thoughts of hurting yourself."

If answer indicates suicidal thoughts, feelings, or plan, the interviewer should say, "It's my responsibility to make sure you are safe. I need you to meet with a counselor to make sure you are safe. I will stay with you until s/he arrives." In the event that this study visit occurs at a community-based agency the group facilitator should follow agency procedures for acute mental health referrals. Group facilitator should contact mental health professional immediately and stay with the participant until agency staff or mental health professional arrives.

IF THE PARTICIPANT DISCUSSED EXPERIENCING OR USING SOME FORM OF ABUSE TO HARM ANOTHER (HOMICIDE) OR THE INTENTION OF HARMING ANOTHER (HOMICIDAL IDEATION), ASK THE FOLLOWING:

"At one point in the interview, you mentioned (being hurt by someone/hurting someone else/being threatened to be hurt by someone/threatening to hurt someone). I would like to ask you more about this to make sure that no one is at risk of being harmed. Is there anything you would like to say about this abuse?"

If yes, interviewer should say, "I'm sorry that's happening. It's my responsibility to make sure you (are safe/do not cause serious harm to another person). I would like you to meet with a counselor to make sure this does not happen. I will stay with you until s/he arrives." In the event that this study visit occurs at a community-based agency the facilitator should follow clinic procedures for mental health and/or potential abuse referrals. Group facilitator should contact stay with participant until supervisor or mental health professional arrives. In addition to mental health services/referrals, the mental health professional will provide appropriate information regarding legal protections and services related to the abuse.

ASK THIS QUESTION OF ALL PARTICIPANTS, REGARDLESS OF THEIR REPORTING OF ABUSE AND/OR SUICIDAL THOUGHTS:

"Is there any (other) part of the interview you would like to discuss further?"

If response indicates the participant is in urgent need of mental health assistance, the group facilitator should follow clinic/agency procedures for acute mental health referrals. Group facilitator should stay with the participant until agency staff or mental health professional arrives. Otherwise, group facilitator should say, "If you decide that you would like to speak with a counselor, here is a list of agencies in the community that provide this service."

Appendix M
Preliminary Screening Interview Guide

Date: ___/___/___

IPV ASSESSMENT [DRAFT]

The following questions are about your intimate relationships. When responding to the questions, please consider "intimate relationships" to include those between you and someone like a primary partner, a boyfriend, a casual dating partner, a lover, a husband, or a sex partner (who may not be a boyfriend/primary partner).

Before we get started, what term do you usually/most commonly use when referring to people who've been your intimate partners (e.g., boyfriend, partner, lover, spouse, etc.)? _____ [Intimate Partner Term]

1. Are you currently involved in an intimate relationship?

Yes

No

1.0a. How long ago was your most recent relationship? _____

1.0b. How long were you in a relationship with this person? _____ [Rec Rel Length]

1.0c. What name should I use when referring to this person? _____ (skip to Item 2.1)

[Recent Partner Name]

1.1.2. What name should I use when referring to your [Intimate Partner Term]? _____ [Current Partner Name]

1.1.3. And, how long have you been in a relationship with [Current Partner Name]? _____ [Current Relationship Length]

ASSESSING INTIMATE PARTNER VIOLENCE

Intimate relationships contain several important elements, including one's happiness and satisfaction with the sense of safety and fairness established between one and one's [Intimate Partner Term].

2. Have you ever been in an intimate relationship in which you could have been happier with yourself or with your partner?

Yes

No

Skip to Item 5

2.1a. How many times in your life have you been in an intimate relationship like this? _____

2.1b. Would you consider your current relationship with [Current Partner Name] to be a relationship where you could be happier with yourself or your partner?

Yes

No

No, relationship was in the past

Skip to item 6

Current Relationship Dynamics

Let's spend a few minutes talking about your current relationship with [Current Partner Name]. You already shared that you've been with [Current Partner Name] for [Current Relationship Length].

Am I correct in saying that you started seeing each other around ___/___/____? (calculate and confirm accurate relationship start date) [Current Rel Start Date]

3. Are you currently living with [Current Partner Name]?

Yes

No

3.0a. Have you ever lived together? Yes | No (skip to item ___)

3.1.1. In the [Current Relationship Length] that you've been with [Current Partner Name], how long in total have you lived together? _____ [Current Rel Cohabiting Length]

3.1a. How long were you in the relationship before you decided to move in together? _____

3.1b. So, am I correct in saying that you first moved in together around ___/___/____? (calculate and confirm accurate move-in date) [Current Live-in Start Date]

Date: ___/___/___

3.1.2. Have there ever been periods of time when you and [Current Partner Name] "took a break" from living together (i.e., temporarily stopped living together)?

Yes

No, we've never stopped living together (skip to item 4)

3.1.2.1a. How many times have you and [Current Partner Name] taken a break from living together? _____

3.1.2.1b. When was the last time you took a break from living together? ___/___/___

3.1.2.1c. (The most recent time this happened) what were the circumstances of why you stopped living together? _____

3.1.2d. Why did you move back in together (if applicable)? _____

4. Have there ever been periods where you broke up with [Current Partner Name]?

Yes

No, we've never broken up (skip to item 5)

4.1a. How many times did you "break up" over the course of your [Current Relationship Length] together? _____

4.1b. When was the last time you broke up? ___/___/___

4.1c. (The most recent time this happened) what were the circumstances leading to your break up? _____

+++++CURRENT RELATIONSHIP

5. Earlier you shared there were elements of your current relationship with [Current Partner Name] about which you could be happier. We're going to spend a few minutes talking about those elements. All of my questions will pertain to your current relationship with [current partner name] only. Please remember, your responses will be held in confidence and not shared with [current partner name].

RELATIONSHIP MILESTONES

You mentioned that your relationship with [Current Partner Name] has lasted [Current Relationship Length]. Milestones exist in every relationship. Milestones are considered major positive or negative events that influence how the relationship grows. Milestones can include: moving in together, changing jobs, adopting a pet, or having a major argument.

Share with me 3 milestones of your relationship, and when they occurred.

Milestone 1: _____ Date: ___/___/___

Milestone 2: _____ Date: ___/___/___

Milestone 3: _____ Date: ___/___/___

FORMS OF VIOLENCE

A. I have a deck of white cards that I'd like to share with you (Introduce Client Deck). I'd like you to go through the deck and pull out the white cards that apply to your behavior throughout the [Current Relationship Length] of your current relationship with [Current Partner Name]. You will have up to 2 minutes to sort through the deck.

B. Now, I'd like you to go through this gray deck of cards (Introduce Partner Deck). This time, I'd like you to go through the deck and pull out the gray cards that reflect [Current Partner Name]'s behavior throughout the [Current Relationship Length] of your relationship. Again, you'll have up to 2 minutes to sort through the deck.

FREQUENCY & PATTERN – Relationship Timeline Exercise

(Clinician: Fill in the Relationship Timeline to include the relationship length, start date, and today's date. Also plot 3 milestones at the appropriate time-points on the timeline.)

Date: ____/____/____

We're going to go back to the cards that you selected earlier, beginning with the white cards that that pertain to your behavior in your relationship with [Current Partner Name].

- o We'll begin to map those cards onto the top of this timeline (present timeline graphic), which represents the [current relationship length] you've been together.
- o Take up to 2 minutes to mark the timeline with the Behavior Code (BC) on the bottom of the card.
- o Please begin from the current state of time and work backwards in time. It's okay if a BC repeats itself on the timeline.

(Allow up to 2 minutes for client to complete top portion of timeline – please ensure that all selected cards are used)

Thank you for filling the top portion out. Now, I'd like you to put the white cards aside, and pick up the gray cards you selected earlier. Remember those gray cards represent your partner's behavior in the relationship.

- o This time take another 2 minutes to plot the gray cards on the bottom half of the timeline.
- o And, just as you did with the white cards, mark the timeline with the Behavior Code (BC) on the bottom of each card.
- o Please begin from the current state of time and work backwards in time. It's okay if a BC repeats itself on the timeline.

(Allow up to 2 minutes for client to complete top portion of timeline – please ensure that all selected cards are used)

Now that you're all finished, take a moment to review the completed timeline.

- o You may make any necessary adjustments to the timeline, but please share why you are making these adjustments.
- o Let me know when you're finished, and we can move on.

+++++PAST RELATIONSHIP+++++

6. Earlier you shared there were elements your past relationship with [Recent Partner Name – item 1.0c] about which you could be happier. We're going to spend a few minutes talking about those elements. All of my questions will pertain to your past relationship with [Recent Partner Name] only. Please remember, your responses will be held in confidence and not shared with [Recent Partner Name] or [Current Partner Name—if applicable].

RELATIONSHIP MILESTONES

You mentioned that your relationship with [Recent Partner Name] has lasted [Rec Rel Length – item 1.0b]. Milestones exist in every relationship. Milestones are considered major positive or negative events that influence how the relationship grows. Milestones can include: moving in together, changing jobs, adopting a pet, or having a major argument.

Share with me 3 milestones of your relationship with [Recent Partner Name], and when they occurred.

Milestone 1: _____ Date: __/__/____

Milestone 2: _____ Date: __/__/____

Milestone 3: _____ Date: __/__/____

FORMS OF VIOLENCE

A. I have a deck of white cards that I'd like to share with you (Introduce Client Deck). I'd like you to go through the deck and pull out the white cards that apply to your behavior throughout the [Rec Rel Length] of your past relationship with [Recent Partner Name]. You will have up to 2 minutes to sort through the deck.

B. Now, I'd like you to go through this gray deck of cards (Introduce Partner Deck). This time, I'd like you to go through the deck and pull out the gray cards that reflect [Recent Partner Name]'s behavior throughout the [Rel Relationship Length] of your relationship. Again, you'll have up to 2 minutes to sort through the deck.

FREQUENCY & PATTERN – Relationship Timeline Exercise

(Clinician: Fill in the Relationship Timeline to include the relationship length, start date, and today's date. Also plot 3 milestones at the appropriate time-points on the timeline.)

We're going to go back to the cards that you selected earlier, beginning with the white cards that pertain to your behavior in your past relationship with [Recent Partner Name].

- o We'll begin to map those cards onto the top of this timeline (present timeline graphic), which represents the [Rec Rel Length] you've been together.

Date: ____/____/____

- o Take up to 2 minutes to mark the timeline with the Behavior Code (BC) on the bottom of the card.
- o Please begin from the current state of time and work backwards in time. It's okay if a BC repeats itself on the timeline.

(Allow up to 2 minutes for client to complete top portion of timeline – please ensure that all selected cards are used)

Thank you for filling the top portion out. Now, I'd like you to put the white cards aside, and pick up the gray cards you selected earlier. Remember those gray cards represent your partner's behavior in the past relationship.

- o This time take another 2 minutes to plot the gray cards on the bottom half of the timeline.
- o And, just as you did with the white cards, mark the timeline with the Behavior Code (BC) on the bottom of each card.
- o Please begin from the current state of time and work backwards in time. It's okay if a BC repeats itself on the timeline.

(Allow up to 2 minutes for client to complete top portion of timeline – please ensure that all selected cards are used)

Now that you're all finished, take a moment to review the completed timeline.

- o You may make any necessary adjustments to the timeline, but please share why you are making these adjustments.
- o Let me know when you're finished, and we can move on.

+++++

BIOPSYCHOSOCIAL HEALTH

7. So far, we've talked about the types of unfair behaviors present in your relationship with [Current or Recent Partner Name].

Please respond to the following questions, which pertain to how this relationship has affected the physical and emotional parts of your life.

	Not at all	Several days	More than half the time	Nearly every day
Since being in this relationship:	0	1	2	3
7.1. I've had little pleasure in doing things	0	1	2	3
7.2. I feel depressed, or hopeless about the future	0	1	2	3
7.3. I have problems sleeping (e.g., too much or too little)	0	1	2	3
7.4. I have developed physical health problems	0	1	2	3
7.5. I have trouble concentrating	0	1	2	3
7.6. I sometimes have nightmares	0	1	2	3
7.7. I have thoughts that I'd be better off dead, or about hurting myself	0	1	2	3
7.8. I have thoughts about hurting my partner	0	1	2	3
7.9. I fear for my safety	0	1	2	3
7.10. I don't feel as comfortable about my sexuality as I once did	0	1	2	3
7.11. My self-esteem is the strongest it's ever been	0	1	2	3

8. Now I want to hear about different aspects of your relationships with other people. I will ask about these relationships as they are now, and also as they were before your relationship with [Current or Recent Partner Name].

8.1. How often do you communicate with your friends?

- o₁ Daily
- o₂ A few times a week
- o₃ About once a week
- o₄ A few times a month
- o₅ About once a month
- o₆ Never
- o₇ Don't know/Decline to answer

8.1a. And compared to one year ago, how often do you communicate with your friends now?

- o₁ More often?
- o₂ Less often?
- o₃ About the same?

Date: ___/___/___

o₄ Don't know/Decline to answer

8.2. How often do you communicate with your family?

- o₁ Daily
- o₂ A few times a week
- o₃ About once a week
- o₄ A few times a month
- o₅ About once a month
- o₆ Never
- o₇ Don't know/Decline to answer

8.2a. And compared to one year ago, how often do you communicate with your family now?

- o₁ More often?
- o₂ Less often?
- o₃ About the same?
- o₄ Don't know/Decline to answer

8.3. How many people could you call when you need to talk about a problem? →

of people

8.3a. And compared to one year ago, do you have:

- o₁ More people to talk to?
- o₂ Fewer people to talk to?
- o₃ About the same?
- o₄ Don't know/Decline to answer

8.4. If you are sick and need help, how many people can come and help you? →

of people

8.4a. And compared to one year ago, do you have:

- o₁ More people to help you?
- o₂ Fewer people to help you?
- o₃ About the same?
- o₄ Don't know/Decline to answer

8.5. If you want to go out and have some fun, how many people can you call to go out with you for fun? →

of people

8.5a. And compared to one year ago, do you have:

- o₁ More people to go out with?
- o₂ Fewer people to go out with?
- o₃ About the same?
- o₄ Don't know/Decline to answer

8.6. When you need to talk to people about your relationship, how many people can you talk to about your relationship? →

of people

8.6a. And compared to one year ago, do you have:

- o₁ More people to talk to?
- o₂ Fewer people to talk to?
- o₃ About the same?
- o₄ Don't know/Decline to answer

Appendix N
Preliminary Listing of Violent Behaviors

Domain of Abuse		Tactic of Abuse (used against partner)	Tactic of Abuse (experienced from partner)
Physical (P)	P1	Slapping him	Being slapped by him
	P2	Shoving or pushing him	Being shoved pushed by him
	P3		
	P4	Hitting him	Being hit by him
	P5	Biting him	Being bitten by him
	P6	Punching him	Being punched by him
	P7	Kicking him	Being kicked by him
	P8	Choking him	Being choked by him
	P9	Physicall beating him	Being physiciall beaten by him
	P10	Stabbing him	Being stabbed by him
	P11	Shooting at him with gun	Him shooting at you with a gun
	P12	Throwing an object at him	Him throwing an object at you
	P13		
	P14		
	P15	Using objects as weapons against him (for example, broomsticks, dishes, belts, etc.)	Him using objects as weapons against you (for example, broomsticks, dishes, belts, etc.)
Emotional/Psych (E)	E1	You constantly criticizing him	Being constantly criticized by him
	E2	Lying to him	Him lying to you (or your belief that he's lied to you)
	E3	Making false promises to him	Hm making false promises to you
	E4	Making fearful looks or gestures at him	Him making fearful looks or gestures at you
	E5	You destroying his personal items	Him destroying your personal items

	E6	You calling him names and ridiculing him	Him calling you names or ridiculing you
	E7	Humiliating or degrading him	Him humiliating or degrading you
	E8	Threatening to physically hurt him	Him threatening to physically hurt you
	E9	Blackmailing him (threatening to harm him if he doesn't do as you say)	Him blackmailing you (threatening to harm you if you don't do as he says)
	E10	Threatening him with suicide or self-injury	Him threatening suicide or self-injury
	E11	You always blaming him for things	Him always blaming you for things
	E12	You manipulating circumstances so he can take the blame (even when it's not his fault)	Him manipulating circumstances in order to blame you (even when it's not your fault)
	E13	You threatening to kill him	Him threatening to kill you
	E14	You withholding affection from him	Him withholding affection from you
Sexual (S)	S1	You withholding sex from him	Him withholding sex from you
	S2	You forcing him into sexual video/photography	You being forced into sexual video/photography
	S3	You shaming him about sexual likes/dislikes or practices	Him shaming you about your sexual likes/dislikes or practices
	S4	You violating boundaries of your relationship (e.g., cheating with others)	Him violating the boundaries of your relationship (e.g., cheating with others)

	S5		
	S6	You forcing him into sex/rape	You being forced into sex/rape by him
	S7	You forcing him into sex acts with others (e.g. forced threesomes, orgies)	Him forcing you into sex acts with others (e.g., forced threesomes, orgies)
	S8	Unwanted physical harm to his "sexual" body parts or areas	Having unwanted physical harm done to your "sexual" body parts or areas
	S9	You forcing him to have unprotected sex with you	Him forcing you to have unprotected sex with him
	S10	You forcing him into sex work/prostitution	Him forcing you into sex work/prostitution
	S11	In BDSM play, you not respecting his safe words	In BDSM play, him not respecting your safe words
	S12	In BDSM play, you refusing to negotiate scene limits with him	In BDSM play, him refusing to negotiate scene limits with you
Financial/Economic (F)	F1	You "garnishing" (withholding) his income/wages	Him "garnishing" (withholding) your income/wages
	F2	You making important financial decisions without consulting with him	Him making important financial decisions without consulting you
	F3	Your refusing to honor financial deals you made with him	Him refusing to honor financial deals you've made with him
	F4	You controlling his use of/access to all economic resources	Him controlling your use of/access to all economic resources

	F5	You stealing money, credit cards, checks from him	Him stealing money, credit cards, checks from you
	F6	You controlling his finances	Him controlling your finances
	F7	You creating circumstances so that he is totally financially dependent on you	Him creating circumstances so that you are totally financially dependent on him
	F8	You refusing to pay shared bills/expenses	Him refusing to pay shared bills/expenses
	F9	You using your's/his economic status to determine power in relationship	Him using your's/his economic status to determine power in the relationship
	F10	Your running up debt that affects household	Him running up debt that affects the household
	F11	You jeopardizing your's/his credit rating	Him jeopardizing your's/his credit rating
	F12	You controlling his access to food, clothes, health care, etc.	Him controlling your access to food, clothes, health care, etc.
Legal (L)	L1	You unjustly using police against him	Him unjustly using police against you
	L2	You interfering with his obligations to job/work	Him interfering with your job/work obligations
	L3	You jeopardizing (or threatening to jeopardize) his immigration status	Him jeopardizing (or threatening to jeopardize) your immigration status

	L4	You filing a restraining order/order or protection against him, even when he is non-violent most of the time	Him filing a restraining order/order of protection against you, even when you are non-violent most of the time
	L5	You violating (or threatening to violate) terms of a restraining order/ order of protection he placed against you	Him violating (or threatening to violate) the terms of a restraining order/order of protection you've placed against him
	L6	You assuming his identity in legal matters or on legally-binding documents	Him assuming your identity in legal matters or on legally-binding documents
Ability/Health Status (AH)	AH1	You blaming him for having a disability or a chronic illness (e.g., HIV, arthritis, diabetes)	Him blaming you for having a disability or a chronic illness (e.g., HIV, arthritis, diabetes)
	AH2	You shaming him for his/your sexual problems or dysfunctions	Him shaming you for your's/his sexual problems or dysfunctions
	AH3	You using your/his illness to justify your unfairness toward him	His using his/your illness to justify his unfairness toward you
	AH4	You threatening to reveal his HIV status to others	His threatening to reveal your HIV status to others
	AH5	You neglecting or withholding access to his medical or social services	His neglecting or withholding access to your medical or social services
	AH6	You reventing him from seeking health care	Him reventing you from seeking health care
	AH7	You disclosing his health conditions to others without his consent	His disclosing your health conditions to others without your consent

Identity (I)	11	You shaming him on account of his masculinity or feminity	Him shaming you on account of your masculinity or feminity
	12	You threatening to out his sexual orientation (or gender identity) to others	Him threatening to out your sexual orientation (or gender identity) to others
	13	You questioning the validity of his gender identity, or sexual orientation	Him questioning the validity of your gender identity, or sexual orientation
	14	You isolating him from LGBT community or friends	Him isolating you from LGBT community or friends
	15	You outing his sexual orientation to others	Him outing your sexual orientation to others
	16	You controlling how he expresses his sexual orientation (how "gay" or "staight" he acts)	Him controlling how you express your sexual orientation (how "gay" or "straight" you act)
	17	You disclosing his gender identity/biological sex to others	Him disclosing your gender identity/biological sex to others
	18	You using homophobia/bi-phobia/trans-phobia to keep him from reaching out to others	Him using homophobia/bi-phobia/transphobia to keep you from reaching out to others

Stalking (ST)	ST1	You showing up unannounced to places he is at	Him showing up unannounced to places you are at
	ST2	You having him "report in" regularly through text/phone call	Him having you "report in" regularly through text/ phone call
	ST3	You "keeping tabs" on him by monitoring his activity on social networking websites	Him "keeping tabs" on you by monitoring your activity on social networking website
Isolating (IS)	IS1	You keeping him from seeing or talking to his friends as often as he used to	Him keeping you from seeing or talking to your friends as often as you used to
	IS2	You keeping him from talking to his family as often as he used to	Him keeping you from talking to your family as often as you used to
Entitlement (E)	E1	You treating him as inferior	Him treating you as inferior
	E2	You demanding that your needs always come before his needs	Him demanding that his needs always come before your needs
	E3	You interfering with his job, personal needs, and other obligations	Him interfering with your job, personal needs, and other obligations
	E4	You putting him down on account of his racial/ethnic background	Him putting you down on account of your racial/ ethnic background
Using Dependents (D) (Children, family, or pets)	D1	You taking/threatening to take his dependents away from him	Him taking/threatening to take your dependents away from you
	D2	You threatening to harm his dependents	Him threatening to harm your dependents
	D3	You threatening to jeopardize parent-child relationships by disclosing his sexual/gender identity or health status	Him threatening to jeopardize your parent-child relationship by disclosing your sexual/gender identity or health status

	D2	You threatening to harm his dependents	Him threatening to harm your dependents
	D3	You threatening to jeopardize parent-child relationships by disclosing his sexual/gender identity or health status	Him threatening to jeopardize your parent-child relationship by disclosing your sexual/gender identity or health status

Appendix O
Preliminary Relationship Timeline Graphic

A

Relationship Timeline

Instructions: The timeline below represents a timeline of your current relationship. Your relationship length and 3 defining moments of your relationship have already been added by your counselor. Using the colored cards you selected earlier, plot the Behavior Codes to areas of the timeline that most accurately reflect when such behaviors occurred. It's okay if the same Behavior Code is repeated at several points throughout the timeline.

Relationship Start Date: _____

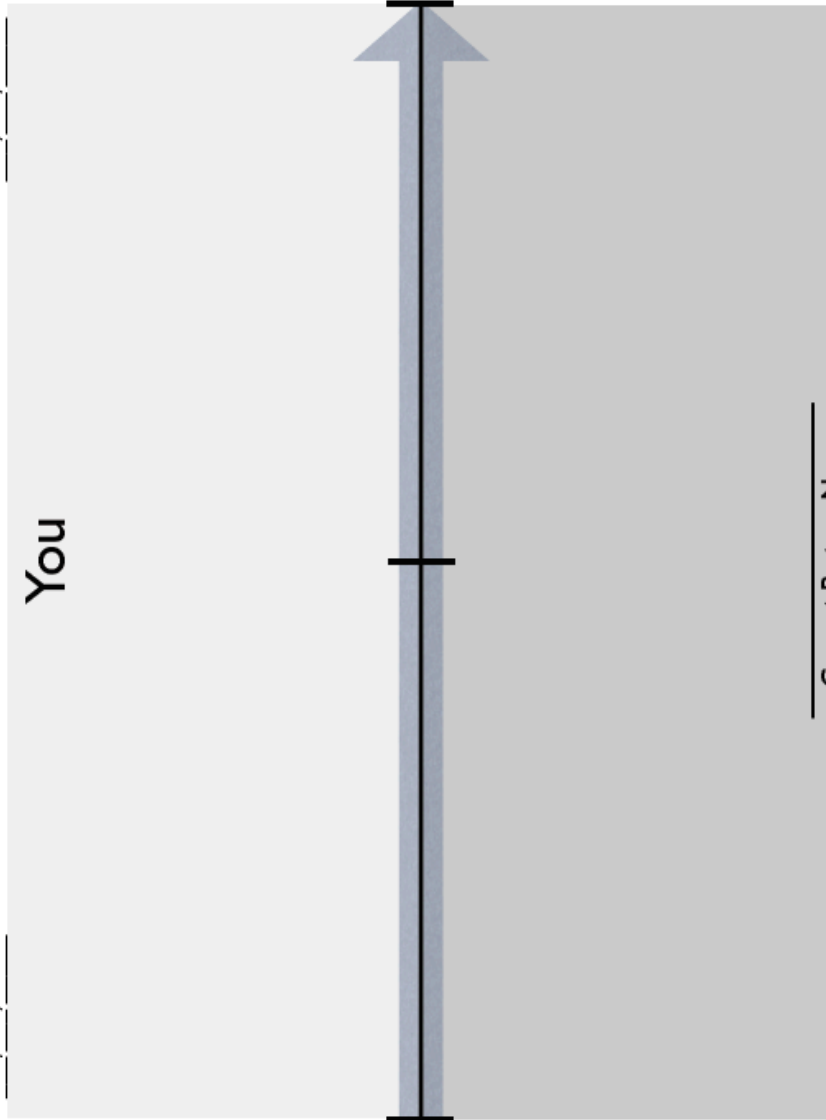
Today's Date: _____

Relationship Length: _____

You

T O D A Y

Current Partner Name



B

Relationship Timeline

Instructions: Use the timeline below as a chronological model of a past relationship. Your relationship length and 3 defining moments of this relationship have already been added by your counselor. Using the top half of your timeline, begin plotting the Behavior Codes to portions of the timeline that most accurately reflect when such behaviors occurred. It's okay if the same Behavior Code is repeated at several points throughout the timeline.

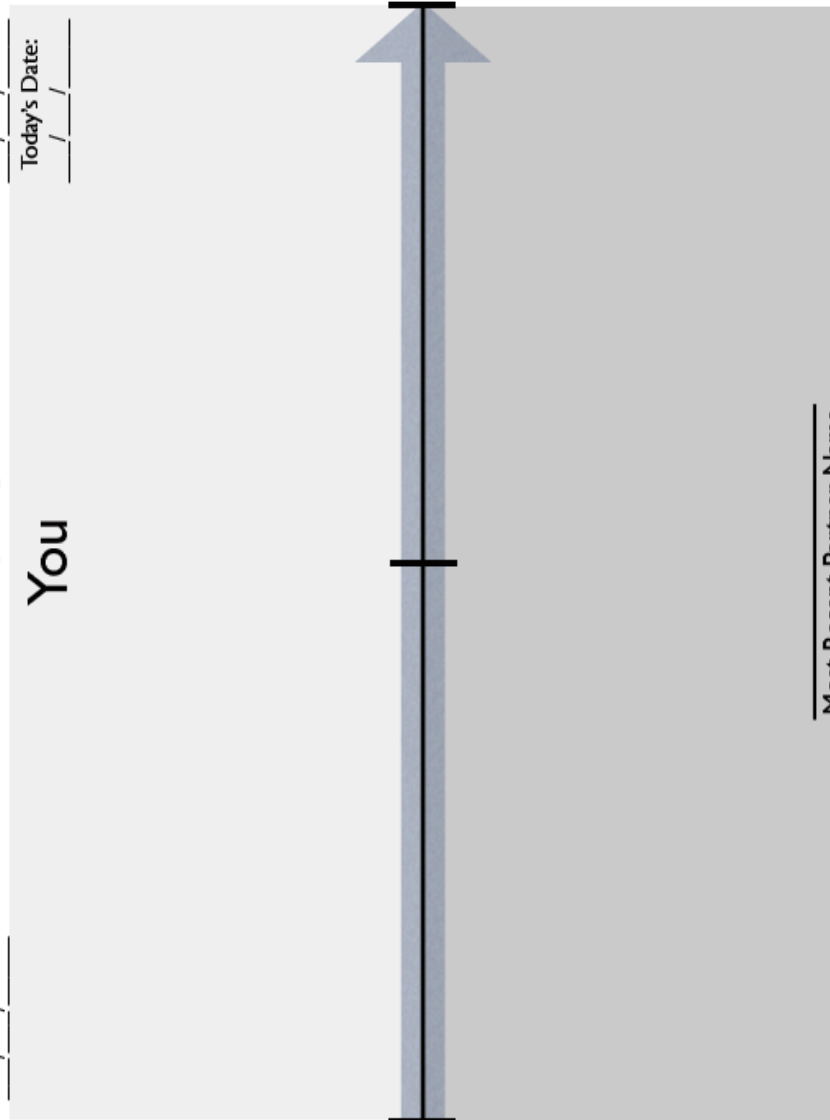
Relationship Start Date: ____/____/____

Relationship End Date: ____/____/____

Relationship Length: _____

You

Today's Date: ____/____/____

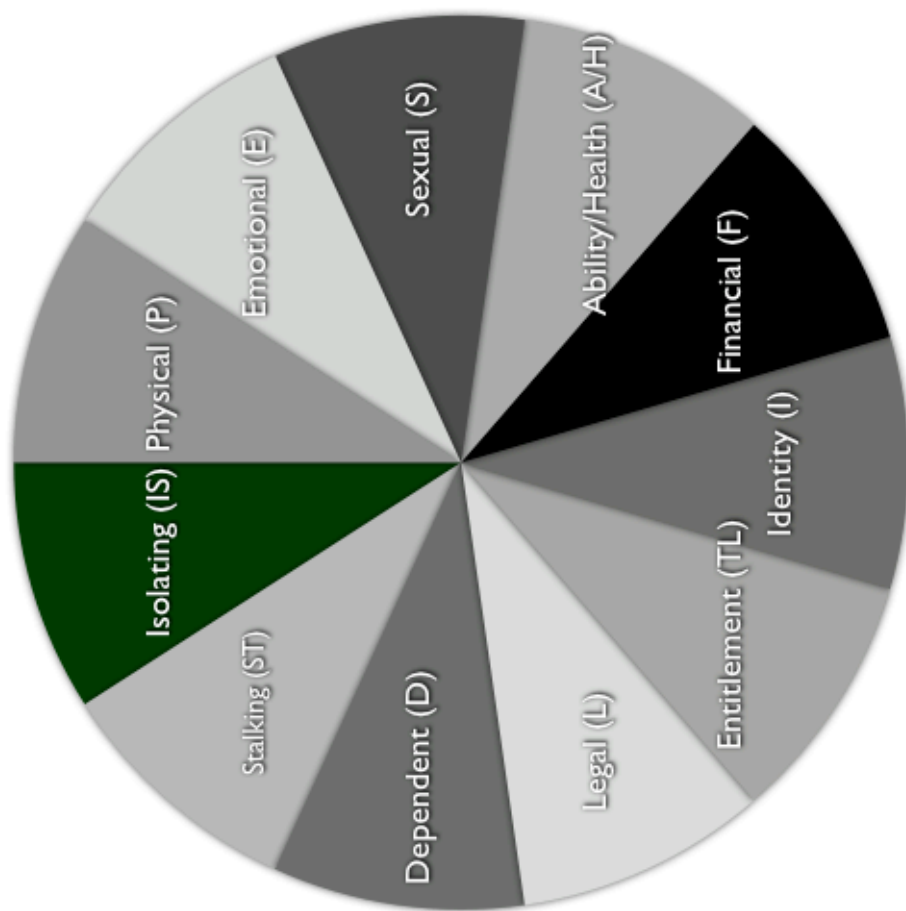


Most Recent Partner Name

Appendix P

Preliminary Chart of Unfair Behaviors

Chart of Unfair Behaviors



Appendix Q

The Fairness and Relationship Equality (FARE) Screener

Fairness And Relationship Equality (FARE) Screener

The following questions are about your intimate relationships. The terms "intimate relationship" refers to relationships between you and someone like a boyfriend, a casual dating partner, a lover, a husband, or a sex partner.

Before we get started, what term do you usually/most commonly use when referring to people who've been your intimate partners (e.g., boyfriend, partner, lover, spouse, etc.)? _____ [Intimate Partner Term]

1. Are you *currently* in a relationship with a _____ [Intimate Partner Term]?
- Yes → *RIGHT TO ITEM 2*
- No ↓ *DOWN TO 'RELATIONSHIP HISTORY'*

RELATIONSHIP HISTORY

I'm going to ask you a few general questions about relationships you've had with [insert Intimate Partner Term]s.

3. Have you ever been in a relationship that you felt was unfair due to things you did to your [insert intimate Partner Term], and/or things your [insert Intimate Partner Term] did to you?

- Yes → *DOWN TO ITEM 4*
- No → *SKIP TO ITEM 10*

4. How many times in your life have you been in an intimate relationship that you felt was unfair? _____

If in current relationship → *RIGHT TO ITEM 4A*

- 4b. How long ago was your most recent relationship that you felt was unfair? _____

- 4c. How long were you in this relationship?
_____ [Rec Rel Length]

- 4d. When did this relationship begin? __/__/__

- 4e. When did this relationship end? __/__/__

- 4f. What name should I use when referring to this person? _____
→ *SKIP TO ITEM 9*

2. What name should I use when referring to your [insert Intimate Partner Term]? _____ [Current Partner Name]

- 2A. And, how long have you been in a relationship with [insert Current Partner Name]? _____ [Current Relationship Length]
↙ *LEFT TO RELATIONSHIP HISTORY*

- 4a. Does your current relationship with [insert Current Partner Name] qualify as a relationship that you feel can sometimes be unfair?

- Yes → *SKIP TO 'CURRENT RELATIONSHIP DYNAMICS' (NEXT PAGE)*
- No, a past relationship ↙ *LEFT TO 4B*

Date: ___/___/___

CURRENT RELATIONSHIP DYNAMICS

Let's spend a few minutes talking about your current relationship with [insert Current Partner Name]. You already shared that you've been with [Current Partner Name] for [Current Relationship Length].

Am I correct in saying that you started seeing each other around ___/___/___? (calculate and confirm approximate relationship start date) **[Current Rel Start Date]**

5. Are you currently living with [insert Current Partner Name]?

- Yes ↓ DOWN TO 5A
 No → RIGHT TO 5B

5a. In the [Current Relationship Length] that you've been with [Current Partner Name], what's the total amount of time that you've lived together? _____
[Current Rel Cohabiting Length]

5c. How long were you in the relationship before you decided to move in together? _____

5d. So, am I correct in saying that you first moved in together around ___/___/___? (calculate and confirm approximate move-in date) **[Current Live-in Start Date]**

6. Have there ever been periods of time when you and [Current Partner Name] "took a break" from living together (i.e., temporarily stopped living together)?

- Yes ↓ DOWN TO ITEM 6A
 No, we've never stopped living together → RIGHT TO ITEM 7

6a. How many times have you and [Current Partner Name] taken a break from living together? _____

6b. When was the most recent time you took a break from living together? ___/___/___

6c. What were the circumstances of why you most recently stopped living together? _____

6d. Why did you move back in together (if applicable)? _____

↗ RIGHT TO ITEM 7

5b Have you ever lived together?

- Yes ← LEFT TO 5A
 No ↓ DOWN TO ITEM 7

7. Have there ever been periods when you broke up with [Current Partner Name]?

- Yes ↓ DOWN TO ITEM 7A
 No, we've never broken up → SKIP TO ITEM 9

7a. How many times did you "break up" over the course of your [Current Relationship Length] together? _____

7b. When was the last time you broke up? ___/___/___

7c. Can you briefly share the circumstances leading up to your most recent break up? _____

↓ CONTINUE TO ITEM 9

Date: ___/___/___

HISTORY OF RELATIONSHIP UNFAIRNESS

(Clinician: Focus on Current Partner if client responded "Yes" to Item 4a above. Otherwise, tailor the following section to Items 4b-4f).

9. Earlier you shared that you felt some things in your [current/past] relationship with [insert Current/Most Recent Partner Name] are/were unfair. I'd like to spend a few minutes learning more about what you meant. All of my questions will pertain to your relationship with [insert Current/Most Recent Partner Name] only. [For individuals with Current Partners:] Please remember, your responses will be held in confidence and not shared with [insert Current Partner Name].

(Clinician: You may choose to remind client about the parameters of confidentiality with respect to child abuse/neglect, homicidality, and suicidality).

Defining Moments of Relationship

I'd like to start by hearing about the "defining moments" of your relationship with [insert Current/Most Recent Partner Name]. "Defining moments" are both good and bad times in a relationship. Some examples of defining moments can include: moving in together, changing jobs, adopting a pet, or having a big argument.

Please share with me 3 defining moments that happened over the course of your entire relationship with [Current/Most Recent Partner Name]. That means one defining moment that marks the beginning, one that marks the middle, and one that marks the [most recent period/end] of your relationship. Please also try to give me the approximate dates these moments occurred.

Defining Moment 1: _____ Date: ___/___/___
(Beginning)

Defining Moment 2: _____ Date: ___/___/___
(Middle)

Defining Moment 3: _____ Date: ___/___/___
(Most Recent Period/End)

Flashcard Activity

A. I have a deck of white cards that I'd like to share with you (*Introduce Client Deck to client*). I'd like you to go through the deck and choose the cards that show the things you've done to [Current/Most Partner Name] over the course of your relationship. You will have a few minutes to sort through the deck.

(Clinician: While client chooses his cards from both decks, (1) fill in the Relationship Timeline to include the relationship length, dividing the timeline by the appropriate amount of units – these may be years, months, or weeks. And, (2) plot the 3 Defining Moments at the appropriate time-points on the timeline.)

B. Now, I'd like you to go through this gray deck of cards (*Introduce Partner Deck to client*). This time, I'd like you to go through the deck and choose the cards that show the things [insert Current/Most Partner Name] has done to you over the course of your relationship. Again, you will have a few minutes to sort through the deck.

Relationship Timeline Exercise

This timeline (*present Relationship Timeline*) represents the [Relationship Length] you've been with [insert Current/Most Recent Partner Name]. The three defining moments you shared earlier are plotted on the timeline. We're going to go back to the cards that you selected earlier, beginning with the white cards. Remember, the white cards are about things you've done to [insert Current/Most Partner Name] over the course of your relationship.

- o We'll begin to plot those cards onto the top portion of this timeline.
- o Instead of writing out the entire phrase of the card on the timeline, you'll simply plot the Behavioral Code (located at the bottom of each card) onto the top half of the timeline. I'll explain how to use these codes once we're all finished completing this exercise.
- o Please make sure that all the cards you've selected are put on the timeline at least once. It's okay if a card shows up on the timeline more than once.
- o Last, you may find it helpful to plot the Behavioral Codes beginning with the current state of time and working backwards in time.

(Allow up to 2-5 minutes for client to complete top portion of timeline – please ensure that (1) all selected cards are used and (2) client is completing the timeline as instructed)

Date: ___/___/___

Thank you for filling the top portion out. Now, I'd like you to put the white cards aside, and pick up the gray cards you selected earlier. Remember those gray cards represent **things [Current/Most Recent Partner Name] has done to you** over the course of your relationship.

- o This time take another 2 minutes to plot the gray cards on the bottom half of the timeline.
- o Now, just as you did with the white cards, plot the Behavioral Code onto the timeline—this time focusing on the *bottom* half of the timeline.
- o Please make sure that all the cards you've selected are put on the timeline at least once. It's okay if a card shows up on the timeline more than once.
- o Last, you may find it helpful to plot the cards beginning with things that happened most currently, and then working backwards in time.

(Allow between 2 - 5 minutes for client to complete bottom portion of timeline – please ensure that (1) all selected cards are used and (2) client is completing the timeline as instructed)

Relationship Timeline Reflection

Thank you for filling out the timeline. Just as I mentioned earlier, I'd like to share how we can use the Behavioral Codes you wrote on your timeline to understand the unfairness in your relationship. Each of those codes corresponds to a category of unfair behaviors listed on this chart (*present the "Chart of Unfair Behaviors"*). Take a look at this chart, and let me know if I can help clarify any of these categories for you. (*Refer to the "Definition of Unfair Behaviors" sheet to define for clients the categories of unfair behaviors.*)

Now, use this chart and the timeline you completed to understand what types of unfair behaviors were present in your relationship with [Current/Most Recent Partner Name].

TOP HALF: The top portion of the timeline represents the things you've done (you did) to [Current/Most Recent Partner Name] over the course of your relationship.

- o What types of unfair behaviors do you see present in the top portion of the timeline? _____

- o What reactions do you have to what you see in this portion of the timeline? _____

BOTTOM HALF: The bottom portion of the timeline represents the things [Current/Most Recent Partner Name] has done to you over the course of your relationship.

- o What types of unfair behaviors do you see present in the bottom portion of the timeline? _____

- o What reactions do you have to what you see in this portion of the timeline? _____

BOTH HALVES TOGETHER: Looking over both portions of the timeline...

- o ...What types of unfair behaviors do you see present in the bottom portion of the timeline? _____

- o What reactions do you have to what you see in this portion of the timeline? _____

SAFETY ASSESSMENT

- o How fearful of **your behavior** toward [Insert Current/Most Recent Partner Name] are you? _____
(Clinician: Assess HI, Duty-to-Warn potential, and/or Risk of Violence)
- o How fearful are you of [Insert Current/Most Recent Partner Name]'s **behavior toward you**? _____
(Clinician: Assess SI, and/or provide appropriate safety planning resources and education)

- o You may make any necessary adjustments to the timeline, but please share why you are making these adjustments.
- o Let me know when you're finished.

Date: ____/____/____

10. Thank you for sharing information about your relationships. How interested are you in talking about your romantic relationships while as a [client/patient] of this organization?

- Very Interested/Somewhat Interested ↓ DOWN TO ITEM 10A
- Not very interested ↓ DOWN TO ITEM 10A
- Not interested at all

10a. What topics or issues related to your intimate relationship(s) are you interested in talking about?

Today's Date: ____/____/____

Relationship Timeline

Instructions: Use the timeline below as a chronological model of your relationship. Your relationship length and 3 defining moments of this relationship have already been added by your counselor. On the top half of the timeline, plot the Behavioral Codes of the white cards you selected. On the bottom half of the time, plot the Behavioral Codes of the gray cards you selected. It's okay if a Behavioral Code is plotted more than once on each half of the timeline.

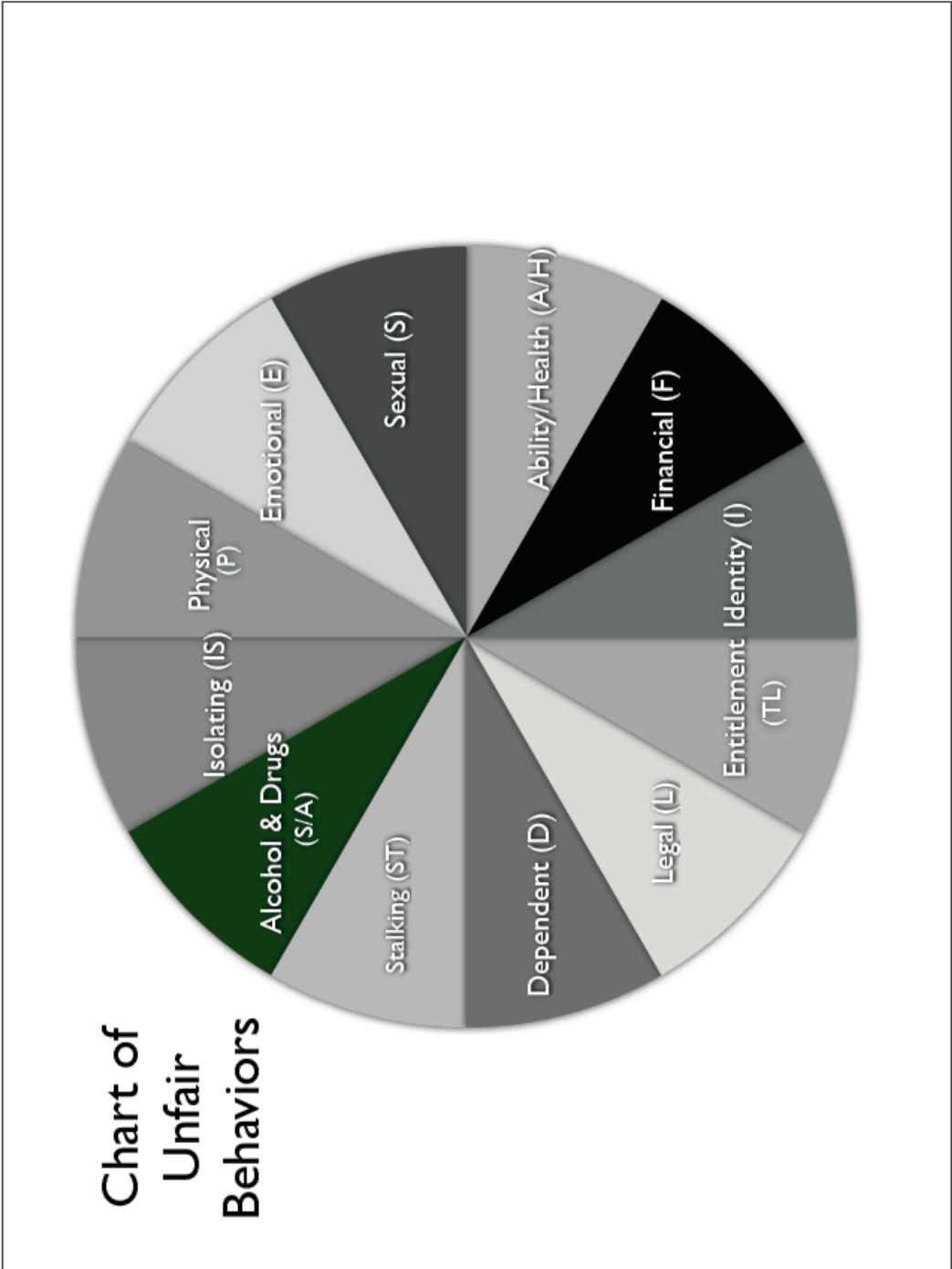
Relationship Total Length: _____

You

Relationship
Start Date: ____/____/____

Relationship
End Date: ____/____/____

Partner Name
(Current) or (Most Recent)
Please Circle One



Appendix R

Additional Flashcards Added to FARE Screener

Drugs & Alcohol (S/A)	S/A1	You giving him alcohol/drugs in order to control him	Him giving you alcohol/drugs in order to control you
	S.A2	You starting fights/arguments with him while you're high or drunk	Him starting fights/arguments with you while he is high/drun
	S/A3	You starting fights/arguments with him IN ORDER to get high/drun	Him starting fights/arguments with you IN ORDER to get high/drun
	S/A4	You taking physical or sexual advantage of him when he is high/drun.	Him taking physical or sexual advantage of you when you are high/drun
	S/A5	You hurting him (or making threats to hurt him) when you are high/drun	Him hurting you (or threatening to hurt you) when he is high/drun
<BLANK> (BL)	BL1		
<BLANK> (BL)	BL2		
<BLANK> (BL)	BL3		