REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-I-18

Subject: Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (903-I-17, first Resolve)

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INTRODUCTION

The first resolve of Resolution 903-I-17, "Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals," introduced by the Medical Student Section and adopted as amended by the House of Delegates asked:

> That our American Medical Association study recent domestic violence data and the unique issues faced by the LGBTQ population.

METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases from January 2008 to June 2018 using the search terms "gay," "lesbian," "bisexual," "transgender," "queer," "LGBT," and "LGBTQ" in conjunction with the terms "intimate partner violence," "domestic violence," and "partner abuse." Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by non-profit and advocacy organizations were also reviewed for relevant information.

CURRENT AMA POLICY

AMA Policy H-160.991, "Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations," recognizes that the physician's nonjudgmental recognition of patients' sexual orientation, sexual behaviors, and gender identities enhances their ability to render optimal patient care." Furthermore, this policy states that our AMA will collaborate with partner organizations to educate physicians on how individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence (IPV), and how sexual and gender minorities present with IPV differ from their cisgender, heterosexual peers and the fact they may have unique complicating factors. The AMA will also promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ survivors of domestic violence (D-515.980, "Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other

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Action of the AMA House of Delegates 2018 Interim Meeting: CSAPH Report 1 Recommendation Adopted as Amended, and Remainder of Report Filed.

Individuals"). AMA Policy H-515.965, "Family and Intimate Partner Violence" broadly addresses the physician's role in IPV and is not specific to patients of a certain gender or sexual orientation. The AMA encourages physicians to routinely inquire about the IPV histories of their patients and upon identifying patients experiencing abuse or threats from intimates, assess and discuss safety issues, and refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible.

BACKGROUND

IPV describes physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner.[1] Examples of intimate partners include current or former spouses, boyfriends or girlfriends, dating partners, or sexual partners. While IPV can occur between heterosexual or same-sex couples and does not require sexual intimacy, much of the efforts to address this public health problem have focused on heterosexual women even though other populations experience IPV at similar rates.

EPIDEMOLOGY OF IPV IN THE LGBTQ POPULATION

Little is known about the national prevalence of IPV in the LGBTQ population in the United States.[2] While a number of small-scale studies have examined violence in the LGBTQ population, the research is difficult to interpret and generalize due to the variability of methodologies utilized, which include different measures of IPV and different time frames to which the violence corresponds (i.e., past year, lifetime).[2-5] In addition, researchers have had difficulty recruiting samples that are representative of the LGBTQ population so the majority of studies have been conducted with small convenience samples.[2-4] A further complication with the research involves the failure to distinguish between sexual activity (behavior) and sexual identity.[3] These factors have resulted in inconsistent findings in terms of victimization rates among these groups.[4;5] For example, a systematic review on IPV in self-identified lesbians found that victimization prevalence in studies ranged between 10 to 51 percent.[3]

In 2010, the Center for Disease Control and Prevention's (CDCs) National Intimate Partner and Sexual Violence Survey (NISVS), provided the first national-level data on the prevalence of intimate partner violence, sexual violence, and stalking among the lesbian, gay, and bisexual (LGB) population by self-reported sexual orientation (transgender individuals were not included in this study).[2] The pattern of results suggests that individuals who self-identify as LGB experience an equal or greater likelihood of experiencing sexual violence, stalking, and intimate partner violence compared with self-identified heterosexuals. The survey found that 61 percent of bisexual women and 44 percent of lesbian women reported experiencing rape, physical violence, and/or stalking within the context of an intimate partner relationship at least once during their lifetime versus 35 percent of heterosexual women.[2] For men, the lifetime prevalence of intimate partner violence was 37 percent for bisexual men, 29 percent for heterosexual men, and 26 percent for gay men.[2]

Limited evidence is available for transgender individuals who may be even more vulnerable to LGBTQ-specific IPV tactics.[4] Findings of lifetime IPV among transgender people range from 31 percent to 50 percent.[6] One study directly compared the lifetime prevalence of IPV among transgender and cisgender people and found that 31percent of transgender people and 20 percent of cisgender people had ever experienced IPV or dating violence.[7]

DISCUSSION

Risk Factors

A number of factors can put LGBTQ individuals at increased risk for IPV victimization and perpetration and many of these risk factors are similar to those among heterosexual individuals. Risk factors for IPV victimization include:

> racial minority status, lower socioeconomic status, younger age, deaf or hard of hearing, substance use/abuse/dependence, low self-esteem, risky sexual behavior, victim blaming attitudes, lack of power in relationships, attachment anxiety, HIV positive status, child abuse, witnessing IPV as a child, victimization in peer networks, psychological and physical health problems, history of sex work, and history of incarceration.[5]

Risk factors for IPV perpetration include:

> interpersonal problems, greater conformity to masculine norms, less secure attachments, greater psychological distress, more substance use/abuse/dependency, high need for control, low socioeconomic status, less education, racial minority status, low self-esteem, more stress, HIV positive status, unprotected sexual intercourse, child abuse, exposure to IPV as a child, disordered personality characteristics, and poor relationship quality.[5]

Identity Abuse Tactics

While some research on the abusive partners use of physical and psychological abuse may be generalizable across communities, unique aspects to LGBTQ relationships are believed to exist. This includes identity abuse (IA), which are abuse tactics that leverage systematic oppression to harm an individual.[8] IA tactics of IPV leverage heterosexism and cissexism against LGBTQ survivors.[8] These tactics including threatening to disclose a partner's LGBTQ status without their consent. This can result in fear of loss of children, employment, housing, or relationships with family and friends.[4] Another IA tactic includes undermining, attacking, or denying a partner's identity as an LGBTQ person.[8] Examples include accusing a partner of being straight, questioning their authenticity, or being prevented from expressing their gender identity. Other IA tactics include using slurs or derogatory language regarding the partners sexual orientation or gender identity and isolating survivors from the LGBTQ community.[8;9] These tactics are also used in threatening partners who seek help.

In examining the prevalence of IA in the LGBTQ community, nearly 17 percent of the sample (n=734) of sexual minority adults reported experiencing at least one form of IA in the last year and 40 percent reported experiencing IA at some point in adulthood.[8] In terms of gender, women (43 percent) experienced significantly more exposure to IA in adulthood then men (24 percent). Trans gender or gender non-confirming participants (50 percent) reported higher rates of IA in adulthood then their cisgender counterparts.[8] In terms of sexual orientation, queer-identified participants (49 percent) and bisexual participants (48 percent) had the highest rates of IA in adulthood (nearly 50 percent) compared with their lesbian (35 percent) and gay (26 percent) counterparts.[8]

Health Outcomes

IPV is associated with poor physical and mental health outcomes. For example, in a study (n = 817) of men who have sex with men there was a significant relationship between a range of health problems and IPV.[10] Abused men were more likely than non-abused men to report problems such as hypertension, heart disease, obesity, smoking-related illness and, to some extent, sexually transmitted infections.[10] Men in abusive relationships were more likely to report depression or other mental health problems, and to engage in unhealthy behaviors such as substance abuse,

combining drugs with sex, or unprotected sex.[10] Another study of LGBT young adults (n=172) found that being a victim of IPV was associated with concurrent sexual risk taking and prospective mental health outcomes, but was not associated with substance abuse.[11]

BARRIERS TO SEEKING HELP

Screening

The medical community has been criticized for neglecting members of the LGBTQ population in their efforts to respond to the problem of IPV.[12] However, research is lacking on the best practices for identifying LGBTQ survivors of IPV.[13] It is unclear if existing tools are relevant to LGBTQ survivors, though limited research suggests that they are and that changes in wording and additional questions could improve their relevancy.[13]

U.S. Preventive Services Task Force (USPSTF). The USPSTF recommends that clinicians screen women of childbearing age for IPV, such as domestic violence, and provide or refer women who screen positive to intervention services (B recommendation).[14] In making this recommendation, the USPSTF examined the accuracy of available screening tests, the effectiveness of early detection through trials examining interventions, the potential harms of screening and interventions, and the estimated magnitude of the net benefit. The USPSTF, in discussing clinical considerations, recognized that a significant body of evidence is lacking for other populations, especially men. It was noted that research is needed in all areas related to screening and treatment in men, as well as reporting, safety, community linkages and supports, legal ramifications, and cultural aspects.[14] The USPSTF is in the process of updating this recommendation, but the draft statement that has been posted indicates that research gaps still exist. However, the draft recommendation does not specifically note the gaps in research related to the LGBTQ population.[15]

Futures Without Violence has collaborated with a number of organizations to develop materials that are specifically for LGBTQ people. The “Caring Relationships, Healthy You” safety cards and poster are survivor-centered tools that are useful conversation starters for health care providers who are doing universal education around healthy relationships and assessing for IPV.[16]

Interventions and Services

In addition to effective screening tools, more research is needed to determine the interventions that are effective in reducing the harms of IPV in the LGBTQ population. For women of childbearing age, effective interventions include ongoing support services focused on counseling and home visits, those that address multiple risk factors (not just IPV), or include parenting support for new mothers.[15] However, IPV interventions should be culturally relevant, tailored to specific groups, and evaluated within those groups.[17]

There is limited knowledge about LGBTQ IPV in the general community and limited resources are available to support LGBTQ survivors.[9] When LGBTQ individuals attempt to access IPV services their options are often severely limited.[12] When services are provided to LGBTQ IPV survivors, the lack of cultural competency and informed support can re-traumatize the victim.[12] Gaps in services include: limited LGBTQ-friendly health care services, lack of adequate training at agencies around LGBTQ issues, limited medical access, and intake forms that are not LGBTQ friendly.[9] A 2010 study by the National Coalition of Anti-Violence Programs surveyed domestic violence agencies, sexual assault centers, prosecutors’ offices, law enforcement agencies, and child victim services (n=648). The survey found that 94 percent of respondents were not serving LGBTQ survivors of IPV.[18] For example, in 2011, more than 60 percent of LGBTQ IPV survivors who sought assistance at a shelter were turned away.[19]

Similar barriers exist in seeking support from law enforcement and the justice system.[4] LGBTQ individuals are hesitant to seek law enforcement assistance and this hesitation is likely due to fear of discrimination or harassment.[4] Furthermore, state laws may not specifically grant protections to LGBTQ survivors. For example, state statutes on protection orders that do not include LGBTQ survivors are often decided on a case-by-case basis and are at the discretion of a judge.[4]

LEGISLATION

Violence Against Women Reauthorization Act of 2013

The Violence Against Women Act (VAWA) reauthorization of 2013 attempted to address the lack of services for LGBTQ survivors by including a non-discrimination clause. This clause provided that no person in the United States shall, based on actual or perceived race, color, religion, national origin, sex, gender identity, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity funded in whole or in part with funds made available under VAWA and any other program or activity funded in whole or in part with funds appropriated by the Office on Violence Against Women.[20] While there has not been an evaluation on the impact of this clause, it is worth nothing that VAWA is up for reauthorization in 2018 and there are concerns this provision may be removed.

CONCLUSION

The lifetime prevalence of IPV in the LGBTQ community is estimated to be comparable to or higher than that among heterosexual couples. While IPV is prevalent across genders and sexual orientations, it remains unclear whether experiences of IPV differ between subgroups within the LGBTQ population. Much of the work that has been done to address the public health problem of IPV has focused on heterosexual women. There is limited information available on the aspects of IPV that are unique to same-sex relationships and the effects on LGBTQ survivors' mental and physical health. Research is also lacking on the best practices for identifying LGBTQ survivors of IPV. It is unclear if existing screening tools are relevant to LGBTQ survivors. In addition to effective screening tools, research is needed to determine the interventions that are effective in reducing the harms of IPV in the LGBTQ population. Furthermore, community resources to support LGBTQ survivors of IPV are limited. While the 2013 reauthorization of VAWA specifically provided for non-discrimination against sexual and gender minorities, the implementation and enforcement of this provision is unclear.

Despite the limited research available on this topic, physicians should be alert to the possibility of IPV among their LGBTQ patients and should familiarize themselves with resources available in their communities for LGBTQ survivors of IPV.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted and the remainder of the report be filed.

1. That Policy, D-515.980 Improving Screening and Treatment Guidelines for ~~Domestic~~ Intimate Partner Violence (IPV) Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (LGBTQ) be amended by addition and deletion to read as follows:

Our AMA will: (1) ~~study recent domestic violence data and the unique issues faced by the LGBTQ population; and (2)~~ promote crisis resources for LGBTQ patients that cater to the specific needs of LGBTQ ~~victims~~ <u>survivors</u> of ~~domestic violence~~ <u>IPV, (2) encourage physicians to familiarize themselves with resources available in their communities for LGBTQ survivors of IPV,</u> ~~and~~ <u>(3) advocate for federal funding to support programs and services for survivors of IPV that do not discriminate against underserved communities, including on the basis of sexual orientation and gender identity, and (4) encourage the dissemination of research to educate physicians and the community regarding the prevalence of IPV in the LGBTQ population, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screenings</u>. (Modify HOD policy)

2. Our AMA encourages research on intimate partner violence in the LGBTQ community to include studies on the prevalence, the accuracy of screening tools, effectiveness of early detection and interventions, as well as the benefits and harms of screening. (New HOD policy)

3. That Policy H-160.991, "Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations," be reaffirmed.

   Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors. (Reaffirm HOD Policy)

Fiscal Note: Less than $1,000

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